REFUSAL OF PERSONAL COVERAGES (Complete if You or Your Dependents are not Enrolling in your company's benefits)

Social Security Number	Employer Name: WEST VALLEY CONSTRUCTION

Last Name **First Name** **M.**

I am refusing my employer's benefit coverage as marked below:

- ☐ **Medical**
- ☐ **Dental**

X____ **Signature of employee** **Date:**____________

X____**Signature of employer** **Date:**____________