**ELECTION TO DECLINE BENEFITS**

I understand that as an employee of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the Episcopal Diocese of Montana, working 20 or more hours a week, I am eligible for medical and dental insurance. An adequate medical and dental plan, as determined by the Diocese annually, is available to me at no cost. For the reasons cited below, I am electing not to take the options noted below:

Medical

Dental

I understand that my employer may not reimburse me for medical premiums from another insurance provider.

Signed:

Date:

Acknowledged:

Name/Title

Date