COUNTY OF MARIN

DEPARTMENT OF
HUMAN RESOURCES

Our Mission: To create a thriving organization, providing meaningful careers in public service.

DEPENDENT - DENTAL AND VISION
WAIVER OF COVERAGE

Instructions
Employees who waive Vision and/or Dental for their dependents must complete the relevant sections of this form.

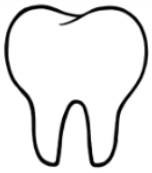
Dependent Vision Waiver

_____ (Print Name) the undersigned, an employee of the County of Marin, hereby warrants to the Human Resources Department, acting for the County of Marin, that she/he waives vision insurance coverage for dependent(s) with the understanding that coverage will not be available unless there is a change of life event or during open enrollment and further releases the County of Marin, its officers, agents and employees from any liability arising from the fact that vision insurance coverage for dependent(s) is waived and hereby waives any rights she/he may have to be afforded vision insurance coverage for his/her dependent(s).

Dependent(s) being waived on the Vision plan:	Date of Birth:

Dependent Dental Waiver

_____ (Print Name) the undersigned, an employee of the County of Marin, hereby warrants to the Human Resources Department, acting for the County of Marin, that she/he waives dental insurance coverage for dependent(s) with the understanding that coverage will not be available unless there is a change of life event or during open enrollment and further releases the County of Marin, its officers, agents and employees from any liability arising from the fact that dental insurance coverage for dependent(s), the premiums of which may be paid in part by the County of Marin, is waived and hereby waives any rights she/he may have to be afforded dental insurance coverage for his/her dependents.



Dependent(s) being waived on the Dental plan:	Date of Birth:

Employee Signature **Date**