

**MagnaCare Minimum Essential Coverage (MEC) Plan
WAIVER OF HEALTH COVERAGE**

I hereby acknowledge that I am withdrawing from my employer's MagnaCare MEC plan. I am aware that by withdrawing, I am acknowledging that I have medical coverage through either another plan on my own or through a spouse/partner for the year of 2024.

In consideration of following my decision to not enroll me in the health plan, I hereby release my employer, its employees, and officers, board of directors, agents, successor and assigns from any and all liability associated with my declination of health insurance coverage.

I HAVE READ THE FOREGOING WAIVER AND FULLY UNDERSTAND ITS TERMS.

Name of Employer: _____

Employee Name (Printed): _____

Last Four of SSN: _____

Email: _____

Signature: _____ Date: _____

Please attach a copy of your existing medical insurance with this waiver in order for us to process your cancellation.

For any questions or concerns, please call our customer service number at (855) 374-6431.

You can fax the waiver form to (833) 930-1023, email to waivers@fbnational.com, or you can send it by mail to:

FBA National
100 Quentin Roosevelt Boulevard Suite 403
Garden City, NY 11530

