

**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 2025.

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 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
333 Earle Ovington Blvd, Suite 510
Uniondale, NY 11553

