2024 WAIVER FORM

Employer Information

Employer Name	Group Number	Date of Hire
A-1 Personnel of Houston, Inc.	FCR8619	

Employee Information

Last Name	First Name	Gender	Social Security #
		☐ Male ☐ Female	
Date of Birth			
Address	City	State	Zip
Email Address		Phone Number	

Medical Coverage Options

☐ **Waive Coverage**

Waiver of Coverage

I elect to waive coverage for myself? ☐ Yes Reason:

I elect to waive coverage for my dependents? ☐ Yes Reason:

Name(s) of Dependent(s) for which to waive coverage:

Signature	Date

Fringe Benefit Group - (866) 866-3424