

# 2025 WAIVER FORM



## Employer Information

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

Last Name	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #
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? <input type="checkbox"/> Yes Reason:	
I elect to waive coverage for my dependents? <input type="checkbox"/> Yes Reason:	
Name(s) of Dependent(s) for which to waive coverage:	
Signature	Date

**Fringe Benefit Group - (866) 866-3424**