HOMECARE WORKER
Benefits Trust

Providing Benefits to Oregon Homecare and Personal Support Workers

Waiver Form

Name Last: _____ **First:** _____

Address: _____ Phone: _____

Email Address: _____ SSN: _____

I acknowledge that I have been offered Dental, Vision and Employee Assistance Program (EAP) coverage through the Oregon Homecare Workers Benefit Trust. By my signature below, I am declining this coverage because:

- ☐ I have coverage through my spouse, partner or parent's employer
- ☐ I have coverage through another employer
- ☐ Other (specify reason)

_____

By signing below, I understand that I am voluntarily waiving my right to coverage for which
I am otherwise eligible through the Oregon Homecare Workers Benefit Trust.

X_____ Date:_____

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P.O. BOX 6, MUKILTEO, WASHINGTON 98275
Trust Administration: 844-507-7554 *fax:* 866-459-4623 *email:* OHCWT@bsitpa.com

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