ShopRite Supermarkets, Inc.
WAIVER OF HEALTH PLAN COVERAGE AND VERIFICATION OF OTHER HEALTH COVERAGE

Email completed from to: veena.sai@wakefern.com or fax to 732-491-4982.

Employee Name: _____ Social Security Number: _____

I understand that I am eligible for health benefit coverage provided under the ShopRite Supermarkets, Inc. Health and Welfare Plan for Full-Time Employees (the "Plan"). The benefits under the Plan and the contribution I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have health benefits from another source:

Name of organization providing coverage: _____
Address: _____
Insurance Carrier: _____
Group Number: _____

I further certify that my dependents have health benefits from another source.

Name of organization providing coverage: _____
Address: _____
Insurance Carrier: _____
Group Number: _____

I, therefore, decline health benefit coverage under the Plan and waive all claims to Plan benefits.

I understand that if I request coverage for myself and/or my eligible dependent(s) at a later date, I may be required to wait until the next open enrollment period (December of each year), if eligible at such time. However, I and my dependent(s) will not be required to wait until the next open enrollment period if:

(1) I and my dependent children, as applicable, are otherwise eligible to enroll in health coverage under the Plan,

(2) The other coverage described above is terminated either as a result of loss of eligibility for coverage, termination of employer contributions toward the coverage or exhaustion of COBRA coverage (in the event the other coverage was provided under a COBRA continuation provision), and

(3) I request enrollment in this Plan within 31 days of the date that coverage terminated.

_____
Signature of Associate

_____ _____
Print Name of Associate Date Signed

IMPORTANT: Although you are refusing health plan coverage, you may be eligible for other benefits (Life and LTD Benefits) under the Plan. These benefits are noted in the Benefits Library. Please complete the life insurance enrollment form and long term disability enrollment and return it with this page to the Benefits Administrator.