

## **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 2026.

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](mailto:waivers@fbnational.com), or you can send it by mail to:

FBA National  
333 Earle Ovington Blvd Suite 510  
Uniondale, NY 11553

