WAIVER OF PARTICIPATION

This form must be returned no later than: _____

The County of Colusa Health Reimbursement Arrangement (the "Plan") provides that a Plan participant may irrevocably waive participation in the Plan.

I hereby waive participation in the Plan.

[ ] For the _____ Plan Year

[ ] Permanently

In making this waiver I understand and represent that:

1. I am giving up a valuable benefit.

2. My waiver of this benefit is irrevocable. Even if I change my mind I will not be allowed to participate in the Plan [at any time during the _____ Plan Year].

3. I am making this waiver before I first become eligible under the Plan.

4. I have been given ample time to read and consider this waiver.

5. I am giving this waiver freely and no one has pressured me into signing the waiver.

Dated _____, 2021.

_____
Participant Signature

_____
Print Participant Name