



Protection Plus™ Waiver Form

Tuesday, May 03, 2005

Company Name: _____
Location: _____
Department: _____
Employee Name: _____
Employee Number: _____
Policy Number: _____

I do not wish to purchase the Protection Plus™ insurance being offered by my employer and Custom Protect Ear Inc.

In declining this insurance, I fully understand that I will not be covered for any of the following reasons:

- The cost of replacing list dB Blocker® hearing protection
- The cost of replacing dB Blocker® hearing protectors that do not fit properly as a result of weight change
- The replacement cost of damaged or stolen dB Blockers®
- An increase in the cost of dB Blocker® hearing protection between the initial fitting and the 5th year refit.

Please initial next to each point above

Associate's Name:
(Please Print)

Company Representative Name:
(Please Print)

Associate's Signature:
(Please Print)

Company Representative Signature:
(Please Print)