HEALTH CARE WAIVER

NAME:_____

SOCIAL SECURITY NUMBER:_____

DEPARTMENT:_____

This waiver is to be completed by employees who **do not wish to enroll** in coverage through the University of Dayton's Group Health Insurance Program, or by employees who are currently enrolled but wish to **cancel** their coverage.

AVAILABLE GROUP HEALTH COVERAGE: *

Anthem Core Plan Anthem Advantage Plan

The above listed health care plans offered by the University of Dayton have been explained to me. After serious consideration, I have decided not to take advantage of this coverage.

I understand that **I will not** be eligible to enroll in health care coverage until the next annual open enrollment period which normally takes place during the month of October with coverage effective January 1st. Enrollment **will be permitted** upon loss of other health insurance coverage if the Office of Human Resources is contacted within thirty (30) days of the occurrence. A letter from the insurance company or employer stating the coverage termination date is required. Enrollment may also be permitted in the case of additional qualifying events as outlined in the Benefit and Leave of Absence Handbooks located on the HR website at www.udayton.edu/~hr/. Proof of the occurrence of one of these events is required.

SIGNATURE:_____DATE:_____

*Proof of insurability may be required for enrollment/re-enrollment into these plans.