EASTERN MICHIGAN UNIVERSITY GROUP MEDICAL HEALTH CARE PLAN
WAIVER OF COVERAGE FORM
(Please Print Clearly)

_____ _____

Last Name First Middle EID or SS#

I hereby waive, for myself and each of my dependents, all eligibility for and/or participation in Eastern Michigan University's group medical insurance plans.

I understand and acknowledge that:

A. Because I am employed by Eastern Michigan University, my dependents and I are eligible for and have been offered the opportunity to participate in a Health Care plan.

B. This waiver will remain in effect until I elect medical insurance coverage under a Health Care plan during a future Eastern Michigan University Open Enrollment period or I enroll in a Health Care plan within 30 days of experiencing a qualified change in status as defined by the Health Care plans.

C. I may be entitled to a Healthcare Waiver Payment ("Waiver Payment") if I am participating in another medical insurance plan (other than EMU's) during the entire period when this waiver is in effect. I am currently participating in the following medical insurance plan:

Plan Name: _____

Coverage Type: _____ Single

_____ Two Person

_____ Family

Name of Employer: _____

Address: _____

_____

Phone number: _____

Waiver Payments are subject to the terms and conditions set forth in the Agreements between Eastern Michigan University and its various non-bargained-for and bargaining units as they may be revised or amended from time-to-time.

_____ _____

Signature Date

_____ _____

Department E-Class

Benefits Office
Revised August 10, 2007

HC Waiver for 2008.doc