

**If you are waiving Aquinas College Health Coverage
(Priority Health HMO)
Please return the following to the Human Resources Department**

**2003
AQUINAS COLLEGE
EMPLOYEE WAIVER OF HEALTH COVERAGE**

"If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption."

I have opted out of health coverage through Aquinas College and instead am covered through _____ Plan.

I hereby certify that the benefits of Aquinas College's Group Benefit Program have been explained to me. I understand the benefits and have been given the opportunity to participate in the program.

I voluntarily and intentionally have decided to waive the health coverage and not participate in this portion of the group benefit plan.

Further, I acknowledge and understand that if, in the future, I and my dependents desire to participate and enroll in health coverage, then it will be necessary for me and my dependents to meet any and all eligibility requirements then in effect.

When enrolled in the Flex Plan, the opt out amount of \$600.00 will be paid in equal amounts.

Signature of Employee/Retiree

Please Print Name

Date