Staff Medical Insurance
Waiver of Coverage Form
2011

EMPLOYEE INFORMATION *(please print clearly)*

Name: ______________________________ G-ID#: ____________________

I hereby waive, for myself and each of my dependents, all eligibility for and/or participation in Oakland University's group medical insurance plan ("Plan") effective January 1, 2011.

I understand and acknowledge that:

A. Because I am employed by Oakland University, my dependents and I were eligible for and had been offered the opportunity to participate in the Plan.

B. The Plan will not pay any medical expenses for me or any of my dependents while this waiver is in effect unless we are covered as eligible dependents of another Oakland University employee who is participating in the Plan.

C. This waiver will remain in effect until December 31, 2011 or I enroll in the Plan within 30 days of experiencing a qualified change in status as defined by the Plan and the relevant Department of Treasury regulations.

D. I may be entitled to a Medical Waiver Payment ("Waiver Payment") if I am participating in another medical insurance plan during the entire period when this waiver is in effect. I am currently participating in the following medical insurance plan:

OTHER COVERAGE INFORMATION

Coverage: ❑ Individual ❑ Group

Plan Name: ______________________________

Plan Number: ______________________________

E. Waiver Payments are subject to the terms and conditions set forth in the collective bargaining agreement, personnel policy manual or individual contract covering my position, as that agreement, manual or contract may be revised from time-to-time.

Signature	*Date*
______________________________	______________________________