University of Massachusetts
UMASS Medical School
Department of Human Resources

Insurance Benefits Waiver Form

The *Insurance Benefit Waiver Form* is to be completed by employees who are declining one or more of the following insurance benefits: Health and Life, Delta Dental, or Long Term Disability

HEALTH AND LIFE INSURANCE WAIVER

I hereby certify that I have been given the opportunity to apply for health and life insurance offered by the Commonwealth of Massachusetts. I further understand that if I wish to enroll in the health insurance program at a later date, I must wait until the annual open enrollment period. My health insurance will then be effective on July 1. If I wish to enroll in the life insurance program in the future, I understand that I must wait one full year and that acceptance into the program is contingent upon providing proof of good health.

_____ _____
Print Name Signature

_____ _____
Social Security Number Date

DELTA DENTAL INSURANCE WAIVER

I hereby certify that I have been given the opportunity to apply for dental insurance offered by the University of Massachusetts Medical School. I further understand that if I wish to enroll in the dental insurance program at a later date, I must wait until the annual enrollment period.

_____ _____
Print Name Signature

_____ _____
Social Security Number Date

LONG TERM DISABILITY INSURANCE WAIVER

I hereby certify that I have been given the opportunity to apply for Group Long Term Disability coverage from The Hartford, a state sponsored disability insurance. I understand fully the benefits available to me under the plan. I decline to participate and hereby waive all benefits of the plan. I further understand that by declining to participate, my right to apply at a later date will be contingent upon the need to provide medical evidence of insurability as specified by The Hartford.

_____ _____
Print Name Signature

_____ _____
Social Security Number Date

Form #: none, Form Date: none