Yale Schools Health/Dental Coverage Waiver Form

Instructions: Please fill out the "Employee Information" section, check the appropriate box(es), print your name on the line, sign and date the form and return to [ENTER NAME AND PHONE NUMBER FOR INDIVIDUAL WHO RECEIVES THE FORM.]

EMPLOYEE INFORMATION	All requested information must be completed – PLEASE PRINT!	
Last Name:	*First Name:*	*Middle Initial:*
Date of Birth:	*Social Security Number:*	*Gender:* ☐ Male ☐ Female
Home Address:		
City: *State:* *Zip:*		*Daytime Phone Number::*

☐ I AM WAIVING MEDICAL COVERAGE FOR MYSELF AND MY ELIGIBLE DEPENDENTS (IF APPLICABLE). I understand that I and my eligible dependents (if applicable) are eligible for medical coverage under **[Yale School plan]**. By completing this form, I acknowledge that I am declining medical coverage for myself and my eligible dependents. I understand that I cannot change this election until the next Open Enrollment period, unless I or my eligible dependent experiences a qualified change event. Furthermore, I understand that if I or my dependent has a qualified status change, it is my responsibility to notify Human Resources within 31 to make any benefits election changes as a result of the qualified change event. I also understand that I may be required to submit documentation to Human Resources as verification that the event has occurred.

☐ I AM WAIVING DENTAL COVERAGE MYSELF AND MY ELIGIBLE DEPENDENTS (IF APPLICABLE). I understand that I and my eligible dependents (if applicable) are eligible for dental coverage under **[Yale School plan]**. By completing this form, I acknowledge that I am declining coverage for myself and my eligible dependents. I understand that I cannot change this election until the next Open Enrollment period, unless I or my eligible dependent experiences a qualified change event. Furthermore, I understand that if I or my dependent has a qualified status change, it is my responsibility to notify Human Resources within 31 to make any benefits election changes as a result of the qualified change event. I also understand that I may be required to submit documentation to Human Resources as verification that the event has occurred.

I understand that if I do not elect dental insurance for myself or my dependent at initial eligibility or I dis-enroll from dental coverage, I and my eligible dependents must wait for an open enrollment period at least 18 months after the last time I/we could have obtained coverage or the date coverage ended. The 18 month waiting period is waived if I or my dependents experience a qualified change event.

Additionally, I agree that I was given the opportunity to enroll in the group health and dental benefits offered by my employer and I understand that, by refusing to enroll, I will have no health /dental coverage available to me and my eligible dependents (which may include my children and/or spouse) if any, through my employer's benefit plan. I understand that I cannot change or revoke this waiver agreement as of any date prior to the next Open Enrollment unless a change in election event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the change in election event, as described in the Plan.

I have read and agree to the terms of my waiver set forth in this agreement. Any previous elect on and agreement under the Plan relating to the same benefits, including any prior election form/salary reduction agreement, is hereby revoked.

PRINT NAME **SIGNATURE** **DATE**