GORDON
COLLEGE

VERIFICATION OF OTHER MEDICAL COVERAGE

MEDICAL WAIVER

Employee's Name: _____

Social Security Number: _____

I understand that I am eligible for the medical benefits under The Gordon College Flexible Benefits Plan. The medical benefits under such plan and the contribution I would have to make to be covered for these benefits have been explained to me in detail.

If you are declining enrollment for your self 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 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of 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. (Heath Insurance Portability and Accountability Act, 1997)

I certify that I have medical benefits under another group insurance plan:

Name of organization providing coverage: _____

Address: _____

Insurance Carrier: _____

Group Number: _____

I, therefore, decline coverage under the Gordon College Flexible Benefits Plan for:

( ) myself ( ) myself and my dependents ( ) my dependents

I understand that if I choose to enroll for the benefits at a later date, I (and/or my dependents may be subject to limitations set by the provider of the Plan.

_____ _____

Date Employee's Signature