WAIVER OF HEALTH INSURANCE

Employee Name _____

Social Security Number _____

Work Extension _____

I **DO NOT** wish to enroll in the Fairleigh Dickinson University Group Health Insurance Program, which includes medical, dental and vision benefits, which I would be eligible for as of the effective date of coverage.

ENROLLMENT POLICY

I understand that I will be eligible to enroll in the Fairleigh Dickinson University Group Health Insurance Program on the first of any month due to any of the qualified life status changes listed below.

Qualified Life Status Changes:

Marriage/Divorce/Legal Separation
Birth/Adoption
Death of a dependent
Gain or Loss of spouse's employment/coverage

_____ _____

Signature Date

Mail form to: Employee Benefits ~ H-DH3-05