# MEDICAL COVERAGE WAIVER (OPT-OUT) STATEMENT
## EFFECTIVE JUNE 1, 2015 – MAY 31, 2016

*This form must be completed if you are waiving coverage under the Daemen College health and dental insurance plan. Please attach a copy of your medical insurance ID card in order to complete the process of waiving (opting out) of coverage.*

I wish to waive the following coverage:

☐ **Medical**

☐ **Dental**

**Employee Name**_____
(Please Print)

**INSURANCE INFORMATION:**
(Please Print)

**Subscriber Name**_____ **Relationship**_____

**Employer or Plan Sponsor Name**_____

**Medical Insurance Carrier**_____ **Policy Number**_____

By signing below, I acknowledge that I have been offered the opportunity to purchase medical and dental coverage through my employer and have chosen to decline coverage, as indicated above. I understand that by opting out as a primary participant, neither I, nor any of my eligible dependents are covered under the Daemen College health and dental plan. However, if my spouse, domestic partner or parent also works for Daemen College, I will be able to receive coverage as a dependent of him/her. I also understand that unless I experience a Qualified Life Event (marriage, reconciliation of legal separation, birth or legal adoption of a child, change in legal custody of dependents, child is no longer eligible for coverage, death of a spouse, spouse gains employment or becomes eligible for benefits through employer, spouse's employment terminates or s/he is no longer eligible for employer benefits, a QMCSO requires me to provide for medical coverage for my child(ren), my spouse or I become eligible for Medicare and elect Medicare as the sole medical coverage), I will be unable to elect coverage until the next open enrollment period with coverage effective June 1st of that year.

**Employee Signature**_____ **Today's Date**_____