PEPPERDINE UNIVERSITY
WAIVER OF GROUP MEDICAL COVERAGE

EMPLOYEE NAME AND ADDRESS

_____

_____

_____

Please list data for self and eligible dependents (spouse & children)

Full Name	SSN	Relation	Date of Birth	Waive (x)	Plan Covered Under (verification attached)

I understand that I am waiving coverage for myself and/or my eligible dependents as I/we are currently covered under another qualifying health benefit plan. I understand that I must provide proof of this coverage under another qualifying health benefit plan in order to fully waive coverage. I further understand by waiving coverage at this time said plan may impose (should I/we later decide to apply for coverage under this plan) an exclusion from the Plan until the next open enrollment period. I also understand that late enrollment in this plan may allow for an additional exclusion of 180 days (6 months) for any pre-existing condition if this provision is included in the plan.

I understand that should I/we lose current coverage under any other health benefit plan as a result of

- Termination of employment of the person through whom I/we are covered.
- Change in the employment status of the person through whom I/we are covered.
- Termination of coverage under the other Plan for myself or my dependents.
- Termination of an employer's monetary contribution toward my coverage under the other Plan.
- Divorce, Legal Separation or Death of the person through whom I am covered as a dependent.
- Declination of coverage when enrollment was previously offered and I subsequently acquired a dependent.

I will have 30 days to enroll in this plan of coverage. Failure to enroll within 30 days of loss of my existing plan will again permit this plan to impose the exclusions citied above.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date