Community College of Philadelphia

Waiver of Group Medical Coverage

_____ I agree to voluntarily waive Community College of Philadelphia coverage to which I am entitled because I am covered under other health coverage. Proof of coverage is attached.

_____ I agree to voluntarily waive Community College of Philadelphia coverage to which I am entitled because I am covered under other dental coverage. Proof of coverage is attached.

_____ I agree to voluntarily waive Community College of Philadelphia coverage to which I am entitled because I am covered under other prescription coverage. Proof of coverage is attached.

_____ I understand that I may resume Community College of Philadelphia coverage if I lose coverage under the other health coverage, provided that I notify the Human Resources Department within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

This is to acknowledge that my employer has explained the available group medical, dental, and prescription coverage to me.

I have been given the opportunity to apply for the available group medical, dental, and prescription coverage and have elected not to enroll myself and/or dependents.

____ ______________

Employee Signature Date

____

Print Name

____ ______________

Human Resources Signature Date