Form updated 4/10/13

MEDICAL PLAN OPT-OUT FORM

2013-2014 Plan Year

1. PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	DAYTIME PHONE ( )
HOME ADDRESS (Number, Street, City, State, ZIP)	WORK EMAIL ADDRESS	PAYROLL DESIGNATION ☐ UNIVERSITY ☐ HOSPITAL

2. OPT OUT OF UNIVERSITY-SPONSORED MEDICAL COVERAGE

I wish to opt-out of the following University-sponsored plan:

☐ Medical

I am opting out of University-sponsored medical coverage because (check one):

☐ I am currently covered as an eligible family member or retiree under a University-sponsored medical plan(s). Covered participant's –

Name: _____

Social Security No.:_____

☐ I am currently covered under a non-University sponsored group **(See proof required under # 3 below.)**

I understand that if I opt-out of University -sponsored medical coverage, Howard University will not provide medical coverage for me or my family members.

3. PROOF OF NON-UNIVERSITY SPONSORED GROUP COVERAGE IS ATTACHED

I am currently covered under a non-University sponsored group and have attached the following proof of coverage:

☐ Copy of medical identification card that displays my name and effective date of coverage

☐ Letter from employer, retirement system or insurance company verifying that I am a covered member under the medical plan including effective date of coverage.

4. RETURN COMPLETED FORM AND SUPPORTING DOCUMENTS NO LATER THAN AUGUST 1, 2013. New Hires must return no later than 30 days from date of hire.

- **University Employees** will return the opt-out form and supporting documentation to the Office of Human Resources, Benefit & Pension Administration by:
  - o Mail/In Person: 2244 10th St., N.W., Suite 422, Washington, DC 20059
  - o Fax: 202-806-7067
  - o Email: benefits@howard.edu
- **Hospital Employees** will return the opt-out form and supporting documentation to the Office of Human Resources, Benefit & Pension Administration by:
  - o Mail/In Person: 2041 Georgia Avenue N.W., Room 2038, Washington, DC 20060
  - o Fax: 202-865-6300
  - o Email: benefits@howard.edu

5. SIGNATURE

My signature below indicates that I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I agree it is my responsibility to contact the Benefits Office within 30 days if there is a change in my status that would necessitate my enrollment in the medical plan.

EMPLOYEE'S SIGNATURE	DATE	RECEIVED BY BENEFIT REPRESENTATIVE	DATE RECEIVED	DATE