HEALTH PLAN WAIVER FORM

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Employee Name (Please Print) USF ID Number

☐ I hereby waive my choice of health plan through USF because I am covered by

________________________ through ________________________

Name of Insurance Company Name of Group or Employer

The subscriber name is ____.

I have attached a copy of my health care card as documentation of this coverage.

I understand that my next opportunity to enroll in a USF health plan will be during an open enrollment period or upon a qualifying event.

I understand that I will begin receiving a health plan waiver credit of $40.00 per month, effective the first day of the month following either the signing of this form or my health plan eligibility date, whichever is later.

☐ I hereby revoke my waiver of the USF health plan.

I have attached an enrollment form for a USF health plan.

I understand that I will no longer receive a health plan waiver credit of $40.00 per month, as of the first day of my enrollment in the USF health plan.

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Signature Date