UNIVERSITY OF HARTFORD

# WAIVER OF GROUP MEDICAL INSURANCE BENEFITS & NOTICE OF SPECIAL ENROLLMENT RIGHTS

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Please complete the following:

Print Name: _____
(Last Name) (First Name) (Middle Initial)

University of Hartford ID#: _____

By signing below, I certify that I have been given the opportunity to enroll in the University of Hartford's group medical insurance plan for myself and my eligible dependents, if any. I am declining enrollment at this time for the following reason:

- ☐ Coverage under my spouse's group medical insurance plan
- ☐ Other coverage _____

I understand that I may be able to enroll in the University of Hartford's group medical insurance plan if I lose my current coverage due to a qualifying event, as defined by the Internal Revenue Service (such as marriage, birth or adoption of a child, loss of employment, divorce or death).

I understand that I have 30 days from the date of the qualifying event to notify the Office of Human Resources Development in order to determine eligibility for enrollment into the University of Hartford's group medical insurance plans. If I do not do so, I understand that I will not be able to enroll in the University of Hartford's group medical insurance plan until the next annual open enrollment period.

I understand that in order to request a special enrollment or obtain more information about the University of Hartford's group medical insurance plan benefits, I should contact my designated Human Resources Service Partner in the Office of Human Resources Development.

_____ _____
Signature Date

Revised 8/2017