Gettysburg College

Verification of Other Medical Coverage Form

Name _____

Social Security Number _____

I understand that I am eligible for health care coverage provided by Gettysburg College. The medical benefits under the plan and the contributions I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have medical benefits under another group insurance plan:

*Full name of principal insured (and relationship)_____

*Name of organization providing coverage_____

*Address_____

*Insurance Carrier(s) and Group Number(s)_____

I, therefore, decline coverage under the Gettysburg College medical plan for me and for my eligible dependents. I waive all claims to medical benefits under the Gettysburg College Plan.

I understand that if I choose to enroll for the benefits at a later date, I (and/or my dependents) will be subject to life event rules.

_____ _____

Signature Witness

_____ _____

Date Date