Kalamazoo VALLEY™ community college

EMPLOYEE HEALTH INSURANCE WAIVER FORM

Employee name: _____ Valley Number: _____

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box below and provide all applicable information.

☐ I am waiving 2021 medical, prescription, vision **and dental** coverage offered by my employer. As of January 1, 2021 I will be covered under another qualified healthcare plan. I understand I will be eligible for $3500 as annual cash-in-lieu of medical insurance and $150 annual cash-in-lieu of dental insurance

Name of Medical Insurance Company_____

Name of Insured_____

☐ I am waiving 2021 medical, prescription, and vision coverage offered by my employer. As of January 1, 2021 I will be covered under another qualified healthcare plan. I understand I will be eligible for $3500 as annual cash-in-lieu of medical insurance.

Name of Medical Insurance Company_____

Name of Insured_____

☐ I am waiving 2021 medical, prescription, and vision coverage offered by my employer. As of January 1, 2021 I will not have medical coverage, have coverage through a parent, have Medicaid or Medicare, or a plan purchased through the Marketplace Exchange.
I understand **I am not** eligible to receive annual cash-in-lieu of medical insurance.

☐ My spouse is also an employee of Kalamazoo Valley. I am insured under their name. I understand I will receive $150 annual cash-in-lieu.

The information provided above is true and accurate to the best of my knowledge.

Employee name _____

Signature_____ Date _____