

**University of St. Thomas
Waiver of Group Insurance Benefits**

Employee Name (please print): _____ **Effective Date:** ____/____/____

First Name: _____ MI: _____ Last Name: _____

Employee Address:

Street: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

UST ID Number: _____ **Gender:** Male Female

Marital Status: Single Married Widowed Other: _____

Waiver of Group Health Insurance Coverage

I have been informed that I am eligible to apply for medical insurance coverage through the University of St. Thomas and have elected to decline coverage at this time. ***I am declining coverage for:***

Myself Spouse Children

Reason for Declining Health Coverage: _____

Name of Health Insurance Carrier*: _____

*University of St. Thomas requires all benefit eligible employees to carry health insurance from some carrier

Waiver of Group Dental Insurance Coverage

I have been informed that I am eligible to apply for dental insurance coverage through the University of St. Thomas and have elected to decline coverage at this time. ***I am declining coverage for:***

Myself Spouse Children

Reason for Declining Dental Coverage: _____

Name of Dental Insurance Carrier (if applicable): _____

Waiver Authorization

By declining health and/or dental coverage under the University of St. Thomas medical and/or dental plan for yourself and/or your dependents, you and your eligible dependents will be eligible to reapply for coverage at the next annual enrollment period, unless you meet the requirements of special enrollment. By signing below, you voluntarily waive the medical and/or dental benefits offered to you and/or your eligible dependents and understand that if you wish to enroll at a later date, you may not be eligible.

Signature: _____ **Date:** _____

Mail completed form to Benefits AQU217 or fax to 651-962-6524