



**DIVISION OF HUMAN RESOURCES
Employee Benefits Administration**

**HEALTH INSURANCE
WAIVER OF COVERAGE**

Employee Name	Social Security Number	Date of Birth	
Address	City	State	Zip Code

I understand that by signing this form I waive my right to the health insurance coverage offered through The George Washington University to its benefits eligible employees. I further understand that I will not be able to elect health insurance coverage until the next annual open enrollment period, unless I experience a qualified life event as established by the Internal Revenue Service.

Employee Signature

Date

Please return completed form to:
Division of Human Resources
Employee Benefits Administration Department
2033 K Street, NW
Suite 220
Washington, DC 20052
Fax: 202-994-9631 E-mail: benefits@gwu.edu