THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

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 _____

Clear Print

Division of Human Resources
Employee Benefits Administration Department
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