

# **TULANE UNIVERSITY MEDICAL PROGRAM MEDICAL WAIVER FORM**

## **Medical Coverage Notice of Enrollment Rights**

**I understand that if I and/or my dependents, if any, waive medical coverage and desire to participate at a later date, coverage can only become effective at the next open enrollment. I further understand if I decline coverage for myself and/or dependents, I must provide proof of my other medical insurance with this waiver form. I may in the future be able to enroll myself (and my dependents) in the medical plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement of adoption, I may be able to enroll myself and my dependents provided I request enrollment within 31 days after that qualifying event.**

**THIS FORM MUST BE SIGNED BY YOU, AND PROOF OF YOUR OTHER INSURANCE COVERAGE MUST BE ATTACHED IN ORDER FOR THIS WAIVER TO BECOME EFFECTIVE.**

\_\_\_\_\_  
Print Name of Employee

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Social Security Number