

Washington College
Verification of Other Medical Coverage Form

Name _____

Social Security Number _____

I understand that I am eligible for health care coverage provided by Washington College. The medical benefits under the plan and the contributions I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have medical benefits under another group insurance plan:

*Full name of principal insured (and relationship) _____

*Name of organization providing coverage _____

*Address _____

*Insurance Carrier(s) and Group Number(s) _____

I, therefore, decline coverage under the Washington College medical plan for me and for my eligible dependents. I waive all claims to medical benefits under the Washington College Plan.

I understand that if I choose to enroll for the benefits at a later date, I (and/or my dependents) may be subject to limitations for pre-existing conditions and required to furnish evidence of continuation of coverage under another plan.

Signature

Human Resources

Date

Date