MARICOPA COMMUNITY COLLEGES

MARICOPA COMMUNITY COLLEGES
EMPLOYEE MEDICAL INSURANCE WAIVER REQUEST
FY 2017-2018

Employee Name: _____ Employee ID#: _____

I hereby request to waive my employee participation in the group medical insurance options available to me through the Maricopa Community Colleges. As indicated by the certification below, I am covered by a group medical insurance program. I understand qualifying coverage includes: military coverage, spouse's coverage, Medicare coverage, retiree coverage or IHS coverage.

I understand that, should I lose coverage due to a change in status, I have thirty (30) days in which to enroll in the Maricopa Community College group medical insurance program.

In lieu of an employer's authorization a copy of a Benefit Confirmation Statement from your employer's or insurer's website may be submitted by the employee. The confirmation statement must include the insured's information, coverage level, a list of covered individuals and the effective date of coverage. The Certification of Coverage section must be completed.

I authorize MCCCD to use or disclose information contained on this form for purposes of verifying health coverage as specified under applicable law.

_____ _____ _____

MCCCD Employee Signature **College** **Date**

CERTIFICATION OF COVERAGE

Insured Name	Insured Phone Number
Insured Employer Name	Insurance Company Name

_____ _____

Insured's Signature authorizing release of information **Date**

INSURED EMPLOYER AUTHORIZATION

Instructions to employer: Please complete the Authorized Signature portion of this form, and return it to MCCCD at the address below as soon as possible.

Our MCCCD employee indicates that coverage is provided for them as:

- ☐ A dependent under your employee listed above. Is this COBRA coverage? ☐ Yes ☐ No
- ☐ An employee or retiree of your Company. Is this COBRA coverage? ☐ Yes ☐ No
- ☐ Military coverage
- ☐ IHS coverage

_____ _____

Insured Employer's Signature **Date**

_____ _____

Title **Phone Number**

Maricopa Community Colleges
Benefits Office
2411 W. 14th Street, Tempe, AZ 85281
480/731-8415 Fax: 480/731-8484