Juniata College

2015 Health Plan Waiver

PARTICIPANT (Please Print)

Last Name	First Name	Middle Initial	Social Security No.

Waiver Agreement

I understand the explanation I have received regarding my decision to waive Health Plan coverage, and I hereby waive my participation for myself and/or dependents in Juniata College's health plan. I understand that a qualified change in Family Status or Loss of coverage (Special Enrollment) will be required to enroll at a later date other than open enrollment.

Signature _____ Date _____

Incentive Election

In order to receive the 2015 Waiver Incentive of $750, I have provided proof of other non-Juniata coverage and have attached the documentation to this form.

I would like to have this incentive disbursed in the following way (check one):

_____ $750 paid in equal monthly installments through payroll (taxed)

_____ $750 deposited into a Health Reimbursement Account (HRA) (non-taxed)

_____ I was given an opportunity to participate but I wish to waive coverage without payment of incentive

Signature _____ Date _____

Return to the Office of Human Resources