Juniata College

2024 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 2024 Waiver Incentive of $1,000.00, I have provided proof of other non-Juniata coverage and have attached the documentation to this form. Please note a medical ID card does not provide dates of coverage and is not an acceptable document.

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

______ $1,000 paid in equal monthly installments through payroll

______ 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