SARAH • LAWRENCE • COLLEGE

PRE-TAX PREMIUMS AND HEALTH BENEFIT WAIVER FORM

Print Name: ____ **Date:**________________________

SS #: ____ **Hire Date:**____________________

PRE-TAX PREMIUM

☐ Yes, I wish to have my Health Care Premiums deducted Pre-Tax from my paychecks.

☐ No, I do not wish to have my Health Care Premiums deducted Pre-Tax from my paychecks.

HEALTH BENEFIT WAIVER

Please **INITIAL** plans you **ELECTED NOT** to participate:

I **wish to participate** in the following Health Care Benefits:

_______ **EPO** Medical Insurance Plan
_______ **EPO2** high deductible Medical Insurance Plan
_______ **POS** Medical Insurance Plan
_______ **Dental** Insurance Plan
_______ **Vision** Plan
_______ **Prime Pay** Flexible Spending Account
_______ **AFLAC** Cancer Supplemental Plan

I **wish not to participate** in the following Health Care Benefits:

_______ **EPO** Medical Insurance Plan
_______ **EPO2** high deductible Medical Insurance Plan
_______ **POS** Medical Insurance Plan
_______ **Dental** Insurance Plan
_______ **Vision** Plan
_______ **Prime Pay** Flexible Spending Account
_______ **AFLAC** Cancer Supplemental Plan

Reason for **electing not to participate** in Sarah Lawrence Health Care benefits:
____

I and my eligible dependents (if applicable) are covered by another employer or other health insurance coverage outside of Sarah Lawrence College; therefore **wish not to participate** in the Health Care benefits initials above.

Signature: ____ **Date:**________________________

IMPORTANT: Please Read and sign acknowledgement:

You must take action **within 30 days** of your hire date to elect benefits and if benefits are not elected within the 30 days you must wait until open enrollment to elect coverage.
If chosen, medical, dental and vision coverage will become effective the first day of the month following the date of hire. Should the first day of employment be the first of the month, benefits are effective on that day.

If you are declining enrollment for yourself or your dependents (including children, spouse or eligible domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that termination of this insurance was a result of a **qualifying event** under the Health Insurance Portability and Accountability Act of 1996, you can request to enroll in the College medical insurance within 30 days after your other coverage ends and you provide proof of prior coverage. If you have a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents, **provided that you request enrollment within 30 days** of the marriage, birth, or adoption. **In addition you may be eligible to enroll in the above plans during open enrollment, which occurs once per year.**

I ____understand the procedure for enrolling and declining Sarah Lawrence health care benefit.

Signature: ____ **Date:**________________________