COMPLETE THIS FORM ONLY IF YOU ELECT TO WAIVE COVERAGE

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL POSTDOC MEDICAL INSURANCE PLAN

WAIVER FORM

Name:_____
(Last) (First) (MI)

Social Security #:_____Department:_____

I have reviewed the information on The University of North Carolina at Chapel Hill Blue Cross and Blue Shield Medical Insurance Plan provided for Temporary Full-Time Postdoctoral Trainees and Postdoctoral Research Associates.

I am aware that if the University supports my medical insurance financially, that amount is limited to no more than what is currently provided under the University's Supplemental Blue Cross and Blue Shield Medical Insurance Plan.

I hereby elect to waive coverage under the University's Blue Cross and Blue Shield Medical Insurance Plan and agree to maintain alternate coverage with the following carrier and notify my departmental manager at the University immediately if my coverage changes or is cancelled.

Please send one copy of this waiver form to Hill, Chesson & Woody and one copy to UNC Payroll Department.

Name of Medical Insurance Company:_____

Policy #:_____

_____ _____
Signature Date