INDIANA UNIVERSITY
HUMAN RESOURCES

IU GRADUATE APPOINTEES & FELLOWSHIP RECIPIENTS

WAIVER REQUEST FORM

Participation in the designated IU-sponsored healthcare program is mandatory for all Graduate Appointees and Fellowship Recipients of Indiana University. Eligible participants will automatically be enrolled in this plan unless a waiver is completed confirming coverage with a comparable plan. Please note that a waiver is required for each plan year, and those who submit a waiver waive all benefits under this program.

I decline to participate in the IU-sponsored healthcare program because of coverage under another medical plan. By signing this form, I request a waiver from the IU-sponsored health care program for the following semester(s): ☐ Fall 2017 ☐ Spring 2018

PERSONAL INFORMATION

Name: _____

Department: _____ **Campus**: _____

University ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **E-Mail**: _____

Please Check All That Apply:

☐ I am a Fellowship Recipient

☐ I am a Graduate Assistant

☐ I am a Postdoctoral Fellow (i.e., T-32 grant)

☐ I am an international student with a non-immigrant visa and will contact my International Student Advisor about health insurance requirements.

AUTHORIZATION/CERTIFICATION

I affirm that the information provided to obtain this waiver is correct to the best of my knowledge. I also acknowledge that the University will discontinue coverage on my behalf for the semesters indicated.

Waiver deadlines: Fall Waiver - September 15th, Spring Waiver - January 31st, or 30 days from date of hire. Late waivers will not be accepted.

If submitting this form electronically, please be aware that by typing your name in the signature box, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. By signing the agreement, you consent to be legally bound by the form's terms and conditions. You further agree that your use of a keyboard, mouse, or other device to type in the provided boxes, to select an item, button, icon or similar act/action in order to provide information required in completing this form is acceptance and agreement as if actually signed by you in writing.

Signature: _____ **Date**: _____/_____/_____

Return Completed Form to:

IU Human Resources
ATTN: Student Insurance Coordinator
Poplars E165, 400 E 7th Street, Bloomington, IN, 47405
Fax: (812) 855-3409
Phone: (812) 856-4650
E-mail: studenhc@iu.edu

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