



UNIVERSITY  
OF SOUTHERN  
CALIFORNIA

## WAIVER OF GROUP HEALTH INSURANCE

By my signature below, I am declining all employer-provided medical coverage during the initial enrollment period or during any subsequent open enrollments for myself and/or any eligible dependent(s).

### Waiving Coverage Because of Other Health Insurance

If you are declining enrollment for yourself or your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in a USC health insurance plan, provided that you request within 30 days after your other coverage ends.

### Conditions of Special Enrollment

If the other coverage was COBRA coverage, then the COBRA coverage must be exhausted for the special enrollment to apply.

If the other coverage was not COBRA coverage, then the other coverage must terminate because of one of the following:

1. Employer contributions towards the coverage has been terminated, or
2. Loss of eligibility under the other coverage, such as:
  - Termination of employment or eligibility, or reduction in work hours
  - Legal separation
  - Divorce
  - Death

Loss of eligibility does not include: (1.) Loss of coverage due to the failure of the individuals to pay premiums on a timely basis, or (2) Termination of coverage for cause, such as fraudulent claims and/or intentional misrepresentation of material fact in connection with the plan.

### Documentation required:

Written verification of the loss of coverage is required. Acceptable documentation would be the COBRA letter indicating the loss of the other coverage, the death certificate, or the court documents for the divorce or legal separation.

### Waiving Coverage, Has No Other Health Insurance

If you waive health insurance and do not have other health insurance and then have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption, or placement for adoption.

\_\_\_\_\_  
PRINT EMPLOYEE NAME

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE