JOHNS HOPKINS
UNIVERSITY

MEDICAL WAIVER FORM

I am aware of, and understand the provisions of the Johns Hopkins University medical plan options available to eligible employees.

Please check the appropriate box:

☐ I elect to waive medical coverage and understand that in order to waive coverage through the university; I must document my coverage under another plan.

☐ I elect to waive medical coverage. My spouse/ domestic partner is a JHU employee and my medical coverage is through their plan with the university.

(PLEASE PRINT OR TYPE)

➢ **JHU Employee Information**

Employee's Name (last, first)	Employee's Social Security Number
Employee's Signature	Date

My coverage is through:

➢ **Policy Holder Information**

Policy Holder's Name (last, first)	Policy Holder's Social Security Number
Policy Holder's Employer Name	
Policy Holder's Medical Insurance Company	Policy Number