

**WAIVER OF MEDICAL BENEFITS ELECTION
FULL-TIME EMPLOYEES**

EMPLOYEE NAME: _____

FT Hire Date: _____ Medical Plan Eligibility Date: _____

As a full-time employee of the [Fashion Institute of Technology](#), I understand that I am eligible to elect health insurance coverage in either the College's Aetna Choice POS II plan or the Aetna HMO plan and that for either individual or family coverage there would be no premium cost to me.

Since I am covered by a medical and hospital insurance plan from another source, I am electing to waive enrollment in FIT's Aetna Choice POS II plan and Aetna HMO plan for myself and (if applicable) my spouse/partner and any dependent children.

I understand by waiving coverage on FIT's Aetna health insurance plans, I will not have any medical or hospital coverage with FIT and I understand that unless I lose the coverage I have listed below, I will not have the option to join either of FIT's Aetna health insurance plans until the next annual open enrollment period for coverage.

I understand that Waiver payments from the College will total \$1,200 for the full calendar year (\$50.00 per paycheck) and will be pro-rated if I am a new employee with a medical plan eligibility date after January 1. Waiver payments are treated as taxable income for payroll purposes.

If I lose the coverage listed below at any time, I agree to notify the Human Resources Benefits area immediately to enroll in either the Aetna Choice POS II or Aetna HMO plan so that I am not uninsured. Waiver payments will cease upon my enrollment in one of the College's Aetna health insurance plans.

OTHER COVERAGE INFORMATION

I am covered for medical and hospital insurance by the plan(s) listed below. I also verify that my spouse and my dependent children (if applicable) are also covered under the plan(s).

Name of Insurance Plan _____ Group/Employer Name _____

Policy Holder Name _____ Group Policy Number: _____

Identification Number _____ Type of Coverage: Medical Hospital Individual Family

Name of Insurance Plan _____ Group/Employer Name _____

Policy Holder Name _____ Group Policy Number _____

Identification Number _____ Type of Coverage: Medical Hospital Individual Family

I have read and understand the terms described above for the Waiver of Benefits Election and I agree to follow these terms. I also agree to provide a coverage verification letter from either the insurance company or the employer listed above. Failure to provide this proof to the Human Resources Office will result in the cancellation of any waiver payments.

EMPLOYEE SIGNATURE

DATE