SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873

Health Plan Form for Employee Declining Coverage

By signing this form, I hereby decline coverage through Southeast Missouri State University for the eligible participants listed below. [*If coverage is being declined for some, but not all, family members, please list here the individuals for whom coverage is being declined*]:

_____

_____

The reason for declining to elect coverage for those listed above is that coverage exists under another group health plan or other health insurance coverage. [*Please specify here the names of the other coverage you have, and your subscriber number(s)*]:

_____

_____

_____

Signature:_____

Printed Name:_____

Date:_____

The University reserves the right to modify or terminate such plans at any time with or without notice. Participation in these plans is provided to eligible employees and does not constitute a guarantee of employment. Participation is subject to the terms and conditions specified in the plan documents