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/same-sex 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 _____

➢ Return completed form by mail, email, or fax to:

Johns Hopkins University | Benefits Service Center
1101 East 33rd Street, Suite D-200 | Baltimore, MD 21218
Fax: 443-997-5820 | Email: benefits@jhu.edu | Phone: 410-516-2000