



**Gwynedd-Mercy College**  
**Verification of Other Medical Coverage**

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

I understand that I am eligible for health care coverage under the health care plans sponsored by Gwynedd-Mercy College. The medical benefits under such plans and the contributions I would have to make to be covered for these benefits have been explained to me in detail. I have read the Notice of Special Enrollment Rights and understand the requirement to decline coverage in writing if I am declining coverage because of other health care coverage.

I hereby decline coverage under the health care plans sponsored by Gwynedd-Mercy College for myself and any eligible dependents for the full year November 1, 2009 – October 31, 2010. The reason for declining coverage for myself and any eligible dependents is that other health care coverage exists for myself and any eligible dependents. Such other health care coverage is as follows:

Full name of principal insured (and relationship) \_\_\_\_\_  
Name of organization providing coverage (i.e., an employer) \_\_\_\_\_  
Address \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Group Number \_\_\_\_\_

I hereby waive all claims against the health care plans sponsored by Gwynedd-Mercy College. I understand that, as a result of this waiver, no medical coverage under any health care plans sponsored by Gwynedd-Mercy College will be provided. I hereby release, and hold Gwynedd-Mercy College, and any health care plans sponsored by Gwynedd-Mercy College, and any Administrators of said plan, harmless for any claims as a result of the failure or refusal to provide medical benefits in accordance with this waiver.

I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct, and complete; and I agree that medical benefits under any health care plan sponsored by Gwynedd-Mercy College will be denied for my submission of any false information on this Verification or any other form.

Please select one:

\_\_\_ By signing below, I am certifying that I am presently covered under a health insurance plan. Since I am not in need of Gwynedd-Mercy College’s medical benefit plans, I elect to have the College remit \$50 per month to my pre-tax elective account with Lincoln National 401(k) Thrift and Retirement Plan.

\_\_\_ By signing below, I am certifying that I am presently covered under a health insurance plan. Since I am not in need of Gwynedd-Mercy College’s medical benefit plans, I elect to have \$50 per month added to my gross pay. I understand this amount will be taxed as ordinary income.

\_\_\_\_\_  
College Representative

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Name (Please Print)

Effective Date of Benefit: \_\_\_\_\_