2006 WAIVER OF GROUP HEALTH INSURANCE

____ ____________________________
Employee Name Social Security Number

WAIVER OF COVERAGE

I do NOT wish medical coverage under the group contract(s) as offered by The University of Akron through the December, 2006 period due to the fact that I have health insurance coverage through

____
(Insurance Provider)

I understand that by signing this Waiver, I am waiving coverage, not only for myself, but for my Spouse and Dependents, if applicable.

Proof of the alternate coverage, such as a copy of the ID card for the alternate plan, must be provided at the time of the election.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CONFIRMING ALTERNATE COVERAGE.

APPLICABLE TO WAIVER

I understand that this is a binding election until revoked during a future enrollment period or by the occurrence of a qualified change in my family status as defined by Internal Revenue Service.

______________________ ______________________________________
Date Signed Employee's Signature

______________________ ______________________________________
Date Received Benefits Administration Personnel Signature

This form may be modified with then-current Internal Revenue Service rules and The University of Akron requirements.