CALIFORNIA STATE UNIVERSITY LONG BEACH Research Foundation

# WAIVER OF HEALTH COVERAGE 2025

Employee Name _____ Campus ID _____

**REASON FOR DECLINING GROUP HEALTH COVERAGE**

I have been offered coverage under the CSULB Research Foundation's group health plan. I voluntarily chose to decline coverage for the following reason (select one):

- ◯ I have coverage under another group health plan
- ◯ I have coverage under an individual health plan
- ◯ Other (please explain)

**PROVIDE THE FOLLOWING INFORMATION**

1. Name of Other Employer or Group Providing Coverage

_____

2. Insurance Company Providing Coverage (Please attach copy of insurance card)

_____

3. Name of Primary Subscriber

_____

**ACKNOWLEDGEMENT**

I understand that by voluntarily declining coverage at this time, I will not be able to enroll in the CSULB Research Foundation group health plan until the next open enrollment period unless I experience a qualifying event. I understand that should a qualifying event occur, I must notify Human Resources within 30 days of the event otherwise I will be required to wait until the next open enrollment period to obtain coverage. I also understand that should I refuse coverage through the CSULB Research Foundation and fail to obtain coverage elsewhere, I will be subject to a penalty under the Affordable Care Act.

Employee Signature _____ Date _____