

WAIVER OF HEALTH COVERAGE 2026

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