COMPLETE THIS FORM ONLY IF YOU ELECT TO WAIVE COVERAGE

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL POSTDOC MEDICAL INSURANCE PLAN

WAIVER FORM

Name:_____
(Last) (First) (MI)

PID:_____ Department:_____

I have reviewed the information on The University of North Carolina at Chapel Hill Blue Cross Blue Shield Medical Insurance Plan provided for Temporary Full-Time Postdoctoral Trainees and Postdoctoral Research Associates.

I hereby elect to waive coverage under the University's Blue Cross Blue Shield Medical Insurance Plan and agree to maintain alternate coverage with the following carrier and notify my departmental manager at the University immediately if my coverage changes or is cancelled.

Please send the completed waiver form to Blue Cross Blue Shield of North Carolina:

PO Box 2073
Durham, NC 27702

email@studentbluenc.com

Name of Medical Insurance Company:_____

Policy #:_____

_____ _____
Signature Date