

Mt. San Antonio College

Medical Benefits Waiver Form

Name:	Employee iD:	Date:	
Address:	City:	State:	Zip Code:
Insurance Carrier Name:	Policy Number:		
Name of Person or Group Provid	ing Medical Coverage:		
	Relationship:		
Employer:			
Please be sure to attach proof of	comparable group insurance	coverage to this j	form.
I,, ack coverage from my employer, Mt. not wish to enroll at this time. I he under the above policy are, at a n Community College District's heal beginning with January 1st of the required to reapply for this waive Mote : In the event of loss of cover of Coverage HBD12A".	San Antonio Community Collectory certify, under penalty of the coninimum, comparable to the country the benefits program. I also un following premium year period reach benefit year during operations.	ege for myself and f perjury, that the overage provided derstand that this d. Finally, I undersen enrollment.	my dependents but do benefits provided by the Mt. San Antonio waiver will be effective tand that I will be
Signature		Date	
	For office use only -		
Approved by:		<u></u>	Date: