The University Corporation, San Francisco State
P.O. Box 320160
San Francisco, CA 94132-0160
(415)338-2246 / fax (415)338-7938

Agreement To Waive Benefits

I, ______________________________, understand that I am eligible for Medical, Dental, and Vision benefits as outlined in the University Corporation, San Francisco State Project Personnel policies. **By signing this agreement I hereby waive my rights to these benefits**.

I further understand by waiving coverage at this time, that should I/we later decide to apply for coverage under this plan; an exclusion from coverage for all pre-existing medical conditions for a period of 12 months may apply. Additionally,

- ➢ I may enroll for coverage offered by the Corporation should I lose my current coverage under *any other* health benefit plan as a result of:
  - Termination of employment of the person through I/we have coverage, or
  - Termination of the plan of coverage, or
  - Employer stops contribution towards employee or dependent coverage, or
  - Divorce, or
  - As a covered employee, a court has ordered that coverage be provided for a spouse or minor child(ren), or
  - In the event of I marry or gain a dependent.

  I will have **31 days** to enroll in *this plan* for coverage. **Failure to enroll within 31 days will again permit this plan to impose the exclusion cited above.**

I understand that I may reverse this waiver during the Corporation's Open Enrollment Period; I will not be entitled to retroactive benefits and that I and / or my dependents may be subject to a waiting period and/or restricted coverage based upon the policies of the individual benefit carriers.

______________________________ ______________
Signature Date