CSU FULLERTON
AUXILIARY SERVICES CORPORATION

Health Coverage Waiver Statement

I acknowledge I have been offered the opportunity to enroll myself and eligible family members in CSU, Fullerton Auxiliary Services Corporation Group Health Plan.

I decline enrolling myself or eligible family members in the group health plan coverage because I have other group medical coverage provided by:

Medical Carrier: _____

Policy/Group Number: _____

Proof of group plan coverage must be attached with this form.

I understand I am eligible to receive flex cash in the monthly amounts indicated below for waiving my coverage/s. My initials below indicate that I will be waiving the following coverage/s:

_____Medical; $349.00 Initials

_____ Dental; $18.00 Initials

_____Vision; $7.00 Initials

I have reviewed the statements on this form and certify that they are true and correct.

_____ Employee Name (print)

_____ Employee CWID

_____ Employee Signature

_____ Date

_____ HR Representative Signature

_____ Date

Effective: 1/1/23
Revised: 12/16/22