

**UNIVERSITY OF DELAWARE  
WAIVER OF MEDICAL INSURANCE**

NAME: \_\_\_\_\_

EMPLOYEE ID: \_\_\_\_\_

Employees are permitted to waive University of Delaware medical insurance coverage if they provide proof of medical insurance coverage elsewhere. If you choose the “no coverage” option for medical insurance, please answer the questions below and return this form to the Office of Human Resources along with a copy of your medical insurance card.

My medical insurance is through:

Subscriber’s name: \_\_\_\_\_

ID number: \_\_\_\_\_

Group number: \_\_\_\_\_

Medical insurance carrier: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date