JOHNS HOPKINS UNIVERSITY

Homewood Postdoctoral Fellows

SHP Health Insurance Waiver Form

Biographical Data: *(all fields mandatory)*

Last Name: _____First Name: _____MI:_____

Date of Birth: _____Hopkins ID: _____Gender: F M

Address:
Street: _____

City:_____ State:_____ Zip: _____ Country: _____

Status:

- ☐ International (F-1, J-1, etc.)
- ☐ US/LPR

Alternate Health Coverage Information *(all fields mandatory)*

Policy # : _____ Insurance Company Name: _____
OR
Group/Cert #: _____

Phone Number and Address for Claims:
_____
_____

A copy of your current health insurance card must be submitted with this waiver form (please list the following plan information, if applicable)

Medical Maximum: _____ (ie. $1000)
Deductible: _____ (ie. $100, $250, none)
Check One:

- ☐ I am covered as a dependent on this policy which is issued to: _____
- ☐ This policy is issued in my name
- ☐ Other: _____

I have read the information describing the SHP Insurance Plan offered through the University, and request a WAIVER of this requirement and benefit. I certify that I have equivalent or better coverage through another plan of insurance and that information provided above is current. When I waive the purchase of the Johns Hopkins SHP, I understand this means I WILL BE RESPONSIBLE FOR ANY MEDICAL EXPENSES WHICH I MAY INCUR.

Signature: _____Date:____/____/_____

RETURN FORM TO:
KSAS/WSE Office of Human Resources,
6th Floor Wyman Park, Suite 650