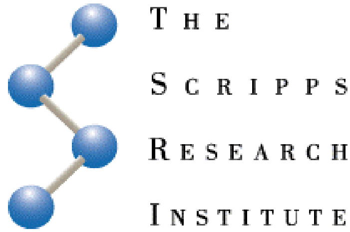

PROOF OF OTHER COVERAGE STATEMENT

If you elected to **WAIVE MEDICAL COVERAGE**, you must complete this form and sign the statement below.

PRINT your name:______________________________ Employee ID: ______________

Last First MI

I have current medical coverage under another plan as indicated below:

____

Source of other coverage (i.e. employer name)

____

Insurance company or the organization providing coverage

I certify that the above information is true and correct as of the date indicated below.

______________________________ ______________

Signature Date

Return the completed form to Human Resources, Benefits Administration – Mail Code TPC11.