

Waiver of health coverage for (name) _____

I acknowledge that I have been offered the opportunity to enroll in the State Health Plan of North Carolina offered by McDowell Technical Community College for all eligible employees.

**Permanent employees working 20 hours a week on a monthly basis or more are eligible to enroll in the State Health Plan of North Carolina.

I acknowledge that I have medical coverage provided by _____.
A copy of the member identification card is attached.

I acknowledge that if I lose health insurance coverage at any time, I will inform McDowell Technical Community College of the change.

Signature

Date