KENT STATE UNIVERSITY

2026 Group Insurance Plan
Affidavit of Alternative Coverage/Refused Medical Coverage

PLEASE CHECK YOUR SELECTION BELOW **BANNER ID: _____**

☐ I hereby elect to **OPT-OUT** of the medical, prescription drug, vision and dental insurance coverage available to me as a benefits eligible employee of Kent State University ("KSU"). In completing this affidavit, I verify I am adequately covered by other medical insurance, not provided by KSU as indicated below and expect to be covered for the entire year. I further acknowledge that I am waiving the health benefits for the entire calendar year and may not re-enroll in the plans during the year except by providing written notice to KSU benefits office that I have incurred a qualifying event. I understand that **I am eligible** to receive an opt-out incentive in the amount of $100.00 per month.

☐ I hereby **REFUSE** the medical, prescription drug, and vision insurance coverage offered to me by KSU. However, I **wish to elect** the dental insurance coverage. By checking this box, I verify I am adequately covered by other medical insurance as indicated below and expect to be covered for the entire year. I further acknowledge that I am waiving the medical, prescription and vision benefits for the entire calendar year and may not re-enroll in the plan during the year except by providing written notice to KSU benefits office that I have incurred a qualifying event. I understand that **I am not eligible** to receive an opt-out incentive.

☐ I am currently covered on KSU benefit plans as a dependent. I further acknowledge that I may not make changes to my enrollment for the entire calendar year except by providing written notice to KSU benefits office that I have incurred a qualifying event. By checking this box, I understand that **I am not eligible** to receive an opt-out incentive.

******NOTICE******

YOU MUST COMPLETE THIS FORM *EVERY YEAR*.

AND

PROVIDE PROOF OF ALTERNATIVE INSURANCE COVERAGE

Name of individual who covers you: _____

Employer of person covering you: _____

Employer Plan Name: _____

Effective Date of Alternate Coverage: _____

Type of Coverage: ☐ Single ☐ Employee + one ☐ Family

_____

Kent State Employee Name **(please print)**

_____ _____

Kent State Employee Signature Date

Division of People, Culture and Belonging

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