AMERICAN UNIVERSITY OF BEIRUT
PERSONNEL DEPARTMENT
Benefits Coordinator's Office

HEALTH INSURANCE PLAN
WAIVER

I, the undersigned **name**_____ **I.D. No.**_____,
hereby declare that I have been informed about the Health Insurance Plan and that its regulations have been explained to me.

I also hereby request exemption from enrolling in the Health Insurance Plan. Further, I fully understand that I will be responsible for payment in full of all expenses incurred at the American University Hospital or any other Hospital.

FOR OFFICE USE ONLY

Witness: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature: _____

Position: _____

Date: _____