



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: \_\_\_\_\_

Policyholder Name: Alay Home Care

Employee Name: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Date of Employment: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey. I refuse the following:

- Employee, Spouse and Child(ren) coverage
 Spouse coverage
 Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- other fully-insured Group Health Plan sponsored by this employer
 other Group Health Plan sponsored by my spouse's employer
 other group coverage sponsored by another organization
 covered under Medicare
 other reasons (please explain) \_\_\_\_\_

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policyholder/Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

Signature of Employee \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Witness \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_