SMALL GROUP HEALTH BENEFITS WAIVER FORM

EmblemHealth®
GHI and HIP are EmblemHealth companies

Group name:			
Group number:			
Employee name:	*Last*	*First*	*Middle Initial*
Date of employment:			
Date of birth:			

I was given the opportunity to enroll in a group insurance health plan offered by my employer and insured by an EmblemHealth affiliated company.

(Note: Benefits provided on a noncontributory basis cannot be refused.)

I am declining to enroll for the reason shown below:

- ☐ Covered by spouse's/domestic partner's group coverage

  Carrier Name and Member ID _____

- ☐ Enrolled in another Insurance Carrier Plan

  Carrier Name and Member ID _____

- ☐ Covered by Medicare
- ☐ Covered by TRICARE or CHAMPVA
- ☐ Other *(Please explain)* _____

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll. By declining this group health coverage I acknowledge that I and my dependents (if any) may have to wait until the plan's next anniversary date to enroll for group health coverage.

_____

Employee Signature Date