EmblemHealth®

HEALTH BENEFITS WAIVER FORM

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

Group Health Incorporated (GHI), GHI HMO Select, Inc. (GHI HMO), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.