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 Parent's/Spouse's/Domestic Partner's group coverage

  Carrier Name and Member ID _____
- ☐ Covered by Medicare/Medicaid
- ☐ Covered by TRICARE or CHAMPVA
- ☐ Covered by Individual Coverage
- ☐ Covered by Veteran's Coverage
- ☐ 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.

Valid waivers are not counted when employers are calculating their total number of eligible employees for plans requiring minimum participation.

_____

Signature Date

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