

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

GROUP NAME

GROUP POLICY NO

EMPLOYEE NAME Last First M.I.

SOCIAL SECURITY #

DATE OF BIRTH Month Day Year
DATE OF HIRE Month Day Year

MARITAL STATUS Single Married Widowed Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Independence Blue Cross through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and Pennsylvania Blue Shield.

I REFUSE the following:

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

REASON FOR REFUSAL (Please indicate all that apply.)

- other group coverage sponsored by my employer
- other group coverage sponsored by my spouse's employer
- other group coverage sponsored by another organization
- other-reasons--please explain

Please provide name of carrier and policy number.

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, and coverage may be subject to a pre-existing conditions exclusions.

Signature of Employee

Date

Signature of Witness

Date

