



**SMALL EMPLOYER HEALTH BENEFITS
WAIVER OF COVERAGE**

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____ Social Security # _____
Last First MI

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 Aetna, Inc. I **refuse** the following:

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

Reason for Refusal (Please check all appropriate boxes.)

- Other group coverage sponsored by my employer
- Other group coverage sponsored by my spouse's employer
- Other group coverage 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.

Signature of Employee

Date

Signature of Witness

Date
