

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____ Social Security # _____
Last First Mid

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 The Guardian or Physicians Health Services of New Jersey, Inc. I refuse the following:

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

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 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 preexisting conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date