

**SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE**

Group Policy No. \_\_\_\_\_

Policyholder Name \_\_\_\_\_

Employee Name \_\_\_\_\_  
Last First MI

Social Security # \_\_\_\_\_

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 United HealthCare. I refuse the following:

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

Reason for Refusal (Please check all appropriate lines)

- other Group Health Plan sponsored by this employer
- other Group Health Plan sponsored by my spouse's employer
- other Group Health Plan sponsored by another organization
- other reasons (please explain) \_\_\_\_\_

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name: \_\_\_\_\_

Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

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 Pre-Existing Condition Statement, and coverage may be subject to a preexisting conditions exclusion.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date