



**SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE**

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

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

Employee Name: \_\_\_\_\_  
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 Horizon Healthcare of New York. 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 this employer (Must provide carrier & group #)
- Other group coverage sponsored by my spouse's employer (Must provide carrier & group #)
- 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 exclusion.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date