oscar

2018 Employee Waiver Form

You, the employee, must complete this waiver. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink, and submit this to your employer when complete.

Section A: Information to be completed by the employer

Employer name	Employer group number (if available)

Section B: Employee information

Employee first name	M.I.	Last name

Social Security Number	Gender	Date of birth (mm/dd/yyyy)
	☐ Male ☐ Female	

Phone number	Email address

Section C: Waiver recipient

Please select the person(s) declining coverage (choose one):

☐ Myself and all dependents ☐ Spouse and children ☐ This dependent only (print full name): _____

☐ Children only ☐ Spouse only

Next, please print the full name and birthdate of all waived dependents on the back of this form →

Section D: Waiver / declining coverage

Reason(s) for declining coverage (please check all that apply):

☐ Covered by a spouse's / domestic partner's coverage
☐ Covered by a parent's / guardian's group coverage
☐ Enrolled in individual insurance
☐ Enrolled in another carrier's group plan sponsored by this employer
☐ Enrolled in Medicare, Medicaid, or Veterans Affairs coverage
☐ I elect not to have coverage
☐ Other reasons (please explain):

_____

Carrier

Policy number

If you chose Medicare / Medicaid / Veterans Affairs as your reason for declining coverage, please specify one below:

☐ Medicare ☐ Medicaid ☐ Veterans Affair coverage

Policy number

Section E: General agreement

Please read this section carefully, and please sign only if declining coverage:

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. By waiving group medical coverage (unless employee and/or dependents have group medical coverage elsewhere) I acknowledge that my dependents and I may have to wait until the next open enrollment to be enrolled in this group's medical plan unless I qualify for special open enrollment.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant signature Sign here	Printed name	Date (mm/dd/yyyy)