

## **Health Benefits Waiver Form**

Group name:			
Group number:			
Employee name:	Last	First	Middle Initial
Date of employm	ent:		
Date of birth:			
I was given the opp EmblemHealth affi		insurance health plan offered by my	/ employer and insured by an
(Note: Benefits p	provided on a noncontribut	ory basis cannot be refused.)	
I am declining to e	enroll for the reason shown b	elow:	
Covere	d by Parent's/Spouse's/Dom	estic Partner's group coverage	
Car	rier Name and Member ID $\_$		
Covered	d by Medicare/Medicaid		
Covered	d by TRICARE or CHAMPVA		
Covered	d by Individual Coverage		
Covered	d by Veteran's Coverage		
Other (	Please explain)		
to enroll. By declin wait until the plant Valid waivers are n	ning this group health cover 's next anniversary date to e	ity to apply for this medical coverage age I acknowledge that I and my dep nroll for group health coverage. are calculating their total number o	endents (if any) may have to
Signature			Date