Horizon

Horizon Blue Cross Blue Shield of New Jersey

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: (For Office Use Only)

Policyholder Name: Nurses 247

Employee Name: _____ Social Security #: _____
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 Blue Cross Blue Shield of New Jersey. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other fully-insured Group Health Plan sponsored by this employer

☐ other Group Health Plan sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ covered under Medicare

☐ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

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 marriage, birth, adoption or placement for adoption.

If the reason for the 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 coverage may be subject to a pre-existing conditions exclusion.

_____ Date: _____ / _____ / _____
Signature of Employee MM DD YYYY

_____ Date: _____ / _____ / _____
Signature of Witness MM DD YYYY