UnitedHealthcare®
OXFORD®

New Jersey Small Employer Health Benefits Waiver of Coverage

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 ▪ 800-385-9088

Group Policy Number:

Policyholder Name:

Employee Name:

Last First Middle Initial

Social Security Number:

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 Oxford Health Plans (NJ), Inc./Oxford Health Insurance, Inc. 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:_____ Policyholder Name:_____

Carrier: _____ Carrier: _____

Policy Number: _____ 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 Conditions Statement, and coverage may be subject to a pre-existing conditions exclusion.

_____ _____

Signature of Employee Date

_____ _____

Signature of Benefits Administrator Date