Small Employer Health Benefits Waiver of Coverage

Employer Information

Group Policy Number	Policyholder Name

Employee Information

Name (Last, First, Middle Initial)		Social Security Number
Marital Status □ Single □ Married □ Widowed □ Divorced	Date of Employment	Date of Birth (MM/DD/YYYY)

Refusal (please check the appropriate box)

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Aetna, Inc. 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 Health Plan sponsored by this employer
□ Other Group Health Plan sponsored by another organization
□ Other Group Health Plan sponsored by my spouse's employer
□ 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	Carrier	Policy Number
Policyholder Name	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 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 pre-existing conditions exclusion.

Signature of Employee	Date (MM/DD/YYYY)
Signature of Witness	Date (MM/DD/YYYY)