AmeriHealth NEW JERSEY

Health Benefits Waiver of Coverage

Please mail to:
AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

Group name	
Group policy #	
Employee name (last, first, mi):	
Social security #	
Date of birth	_____/_____/_____
Date of hire	_____/_____/_____
Marital status	☐ Single ☐ Married ☐ Widowed ☐ Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by AmeriHealth New Jersey.

I REFUSE the following:

- ☐ Employee, Spouse and Child(ren) Coverage
- ☐ Spouse Coverage
- ☐ Child(ren) Coverage

Reasons for Refusal (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ other reasons - please explain: _____

Please provide name of carrier and policy number: _____

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.

Signature of Employee:

Date: _____/_____/_____

Signature of Witness:

Date: _____/_____/_____