



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name _____

Employee Name _____
 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 Oscar. 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 or parent's employer

___ other Group Health Plan sponsored by another organization

___ covered by Medicare, Medicaid, Tricare, or NJ FamilyCare

___ 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 30-90 days (depending on the reason your coverage terminated) after your other coverage ends. Please refer to Oscar's Underwriting Guidelines, located at <https://www.hioscar.com/brokers/forms/small-group>, for more detail. 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 30-90 days (depending on the qualifying life event) after the marriage, birth, adoption, or placement for adoption. For more information please refer to Oscar's Underwriting Guidelines.

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