healthfirst
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group Waiver of Coverage Application

Mailing Address:
Healthfirst Insurance Company, Inc., P.O. Box 1566, New York, NY 10008-1516
Broker Services: **1-855-456-3668**
Employer Services: **1-855-949-3668**

Section 1 | Employee Information

Company Name: ______________________________ **Employee Name:** __________________________

Date of Birth: _________/_________/_________ Date of Employment: _________/_________/_________

Section 2 | Waiver of Coverage

Please complete the below if medical/dental coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Medical coverage declined for:

- ☐ Self
- ☐ Family member(s)

Name(s):

____
____
____
____

Reason for declining coverage:

- ☐ Spouse/Domestic Partner group coverage
- ☐ Parental coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Individual coverage – On or Off Exchange/Marketplace
- ☐ Insurance through another job
- ☐ TRICARE military coverage
- ☐ VA coverage
- ☐ Other_____________________

Section 3 | Acknowledgment

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for, those individuals marked as waiving coverage in Section 2. By waiving coverage, I recognize that those individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). For anyone whose coverage I have waived because of other healthcare coverage or group health coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided that I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid, Child Health Plus, or The Essential Plan). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days of any of the aforementioned events.

Employee Signature	Employee Email Address	Date (MM/DD/YYYY)
______________________________	______________________________	____ /____ /______

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Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone: 1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email: http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-305-0408 (TTY: 1-888-542-3821).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu

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