

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

CUSTOMER NAME

EMPLOYEE NAME Last First M.I.

SOCIAL SECURITY #

DATE OF BIRTH Month Day Year DATE OF HIRE Month Day Year

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 Independence Blue Cross through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and Pennsylvania Blue Shield.

REASON FOR REFUSAL (Please indicate all that apply.)

- other group coverage sponsored by my employer *
- other group coverage sponsored by my spouse's employer
- other-reasons--please explain

* Must meet participation guidelines, if applicable.

I understand that if I wish to enroll for any of the coverage refused, I will be required to submit an Enrollment Form.

Signature of Employee

Date

Signature of Witness

Date

