

AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
8000 Midlantic Drive 1 Suite 333
Mt. Laurel, NJ 08054



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

POLICYHOLDER NAME: _____		GROUP POLICY NO.: _____	
EMPLOYEE NAME: _____		_____	
	Last	First	Middle
SOCIAL SECURITY #: _____	DATE OF BIRTH: _____	DATE OF EMPLOYMENT: _____	
MARITAL STATUS:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey. 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 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, and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date