

**Small Employer Health Benefits  
Waiver of Coverage**



Group Policy Number	Policyholder Name
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Employee Name (Last, First, MI)	Social Security #
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Date of Employment	Date of Birth
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I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by CIGNA. I *refused* the following:

- Employee
- 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 Health Statement, and coverage may be subject to a preexisting conditions exclusion.

Signature of Employee	Date
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Signature of Witness	Date
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