GUARDIAN® Health Net®
Northeast Regional Office
PO Box 26050
Lehigh Valley PA 18002-6050

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____ **Social Security #** _____
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 Guardian or Health Net of New Jersey, Inc. 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 employer**
☐ **Other Group Health Plan sponsored by another organization**

☐ **Other reasons (please explain)** _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

1) Policyholder Name: _____

Carrier: _____ **Policy Number:** _____

2) 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 90 days after your other coverage ends. 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 90 days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to a preexisting condition exclusion.

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 preexisting condition exclusion.

_____ _____
Signature of Employee **Date**

_____ _____
Signature of Witness **Date**