WELLCHOICE®

WAIVER OF COVERAGE

Group Policy No.: _____

Company Name: _____

Employee Name: _____
Last First Middle Initial

Social Security No.: | | | | - | | | - | | | | |

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 WellChoice used 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 by another organization
- ❒ Other reasons (please explain)
- ❒ Individual coverage
- ❒ Medicare
- ❒ Medicaid
- ❒ Other government plans
- ❒ Refusal

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

Carrier: _____

Policyholder Information: _____

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 30 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 30 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 the pre-existing conditions 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 Pre-Existing Condition Statement, and coverage may be subject to a pre-existing conditions exclusion.

_____ _____
Signature of Employee **Date**

_____ _____
Signature of Witness **Date**

10 TELEPORT DRIVE, STATEN ISLAND, NEW YORK 10311

Services and products provided by WellChoice Insurance of New Jersey, Inc. and WellChoice HMO of New Jersey.