AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
8000 Midlantic Drive ♦ 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: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] 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

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