New York Health Benefits Waiver of Coverage

UnitedHealthcare® Oxford

Mailing Address: Oxford Enrollment Dept. ■ P.O. Box 29142 ■ Hot Springs, AR 71903 ■ 1-800-444-6222 ■ www.oxfordhealth.com

Group Name: _____

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in the Oxford* group health benefits plan(s) offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

❑ I have other coverage from:

- ❑ My spouse's employer
- ❑ Medicare
- ❑ Medicaid
- ❑ Veteran's Administration
- ❑ Union health plan
- ❑ Another carrier's group health plan sponsored by this employer
- ❑ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of Carrier Policy Number

❑ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Signature of Employee Date

Signature of Benefits Administrator Date