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 Capital District Physicians' Health Plan, Inc. (CDPHP) and refused.

Reason for refusal (Please check all appropriate boxes):

↓ Other group coverage offered by my employer
↓ Other group coverage offered by my spouse's employer
↓ Other group coverage offered by another organization
↓ Other reason (explain)_____
↓ Individual coverage
↓ Medicare
↓ Medicaid
↓ Other government plan

Please identify alternate health plan(s), including name(s) of policyholder(s) and policy number(s):

Carrier:_____

Policyholder information: _____

↓ Employee, spouse, and child(ren) coverage
↓ Spouse coverage ↓ Child(ren) coverage

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.

Please be assured that all information provided to CDPHP on this form will be held in strict confidence. It will not be shared with any other entity or used for any purpose other than to verify your group's adherence with our underwriting guidelines.

Employee Signature_____ Date_____

Group Benefits Administrator Signature_____ Date_____

Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206