

Small Employer Health Benefits Waiver of Coverage

CIGNA HealthCare



GROUP POLICY NO.	POLICYHOLDER NAME		
EMPLOYEE NAME (Last, First, M.I.)			SOCIAL SECURITY #
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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 CIGNA. I *refuse* the following:

- Employee
- 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 Health Statement, and coverage may be subject to a preexisting conditions exclusion.

SIGNATURE OF EMPLOYEE	DATE
SIGNATURE OF WITNESS	DATE