

# New York Health Benefits Waiver of Coverage



Mailing Address: Oxford Enrollment Dept. ■ 14 Central Park Drive ■ Hooksett, NH 03106 ■ 1-888-201-4216 ■ 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

\* Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Copyright © 2011 Oxford Health Plans LLC. All rights reserved.