Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

CUSTOMER NAME

EMPLOYEE NAME

Last First M.I.

SOCIAL SECURITY #

DATE OF BIRTH Month Day Year

DATE OF HIRE Month Day Year

MARITAL STATUS ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Independence Blue Cross through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and Pennsylvania Blue Shield.

REASON FOR REFUSAL (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer *****
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other-reasons--please explain

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***** Must meet participation guidelines, if applicable.

I understand that if I wish to enroll for any of the coverage refused, I will be required to submit an Enrollment Form.

Signature of Employee Date

Signature of Witness Date