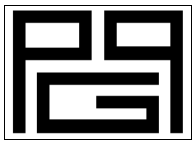

PROFESSIONAL GROUP PLANS, INC.

Specializing in Employee Benefits

Oxford Health Plans
New Jersey
New Business Submission
Checklist

___ Oxford New Jersey Employer Application

___ Employer Certification Form

___ New Jersey Employee Enrollment Form(s)

___ Waiver Form(s)

___ First Month's Premium Check Payable to:
Oxford Health Plans

___ Forms Must Be Submitted to PGP
5 days prior to the effective date.

First time case submission needs licensing forms.

If you have any questions, please contact your PGP representative.

225 Wireless Blvd., 2nd Fl. • Hauppauge, New York 11788 • Tel: 631.951.9200 • Fax: 631.951.9623 • www.pgpbenefits.com

Oxford Health Plans®

Application for a New Jersey Small Employer Health Benefits Policy

Oxford Health Insurance, Inc.
Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 ▪ www.oxfordhealth.com

Please print or type

Policy Number (OHI Use Only): _____

❑ **New Policy** ❑ **Change in Policy** **Requested Effective Date:** _____

I. POLICYHOLDER INFORMATION

1. **Policyholder (full legal name of company):**

2. **Tax Identification Number:**

3. **Main Address:** Street / City / State / Zip Code

Mailing Address: Street / City / State / Zip Code

Telephone & Facsimile: Fax

4. **Name of Correspondent:**

5. **Type of organization:** ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other (explain)_____

6. **Nature of business (specify):** _____ **SIC Code:** _____

7. **Number of eligible employees in your company:** _____
REFER TO NEW JERSEY SMALL EMPLOYER CERTIFICATION FOR THE DEFINITION OF AN ELIGIBLE EMPLOYEE.

8. **Number of eligible employees to be insured:** _____

9. **Class or classes to be excluded:** _____

10. **Insurance Requested For:** ❑ Employees Only ❑ Employees and Dependents

11. **Are you subject to the requirements of COBRA?** ❑ Yes ❑ No

12. **Waiting period before employees become insured: (may not exceed 6 months)**
Present employees _____ New or rehired employees _____

13. **What percentage of the premium will the employer pay?** _____

14. Deposit $_____ **Premium Paid:** ❑ Monthly ❑ Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries, or branches (must be included for purposes of participation).

Legal Name and Location	Number eligible employees in this company	Number eligible employees to be insured

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION 1 OR 2.

SECTION 1: FREEDOM PLAN & LIBERTY PLAN

HEALTH BENEFITS

Plan: ❑ A ❑ B ❑ C ❑ D ❑ E ❑ HMO

Product: ❑ Indemnity (A or B) ❑ PPO (B or C) ❑ PPO (C or D) - Liberty Network only ❑ POS (C,D, or E)

Network: ❑ Freedom ❑ Liberty

Copayment (Plans C,D,E,HMO): ❑ $5 ❑ $10 ❑ $15 ❑ $20

Deductible (B,C, D,E) ❑ $200 ❑ $250 ❑ $500 ❑ $750 Rider ❑ $1,000 ❑ $2,000 ❑ $2,500

OPTIONS FOR PLANS B, C, D AND E ONLY:

❑ Plan B Coinsurance Option: 80/20% in-network and 60/40% out-of-network

❑ Plan C Coinsurance Option: 90/10% in-network and 70/30% out-of-network

❑ Copayment Physician Visits for Preventive Care at No Charge

❑ Copayment Hospital Confinement at No Charge

Coinsured Charge Limit: ❑ $5,000 Rider ❑ $8,333 Rider

❑ Physical Therapy 90 Rider

❑ Vision Care Rider

❑ Enhanced Dental Rider

❑ Premium Dental Rider

PRESCRIPTION DRUG BENEFITS

Program Type: ❑ Standard (Plan Copay)

Optional Riders (Generic/Preferred Brand/Brand copay) :

❑ $5/$15/$50 ❑ $7/$20/$50 ❑ $7/$15/$35 ❑ $10/$25/$50

Pharmacy Deductible Options (Waived for generic drugs): ❑ None ❑ $50

SECTION 2: FREEDOM PLAN DIRECT & LIBERTY PLAN DIRECT PLANS

HEALTH BENEFITS

Plan: ❑ C

Product/Network: ❑ Freedom Plan Direct ❑ Liberty Plan Direct

Copayment: ❑ $30 ❑ $15 PCP/$25 Specialist

Deductible*: ❑ $500 ❑ $1,000

*These deductible amounts apply for both in- and out-of-network benefits

DIRECT OPTIONS:

Coinsured Charge Limit: ❑ $10,000

❑ Vision Care Rider

❑ Enhanced Dental Rider

❑ Premium Dental Rider

(continued on next page)

II. SPECIFICATIONS FOR COVERAGE (CONT'D)

PRESCRIPTION DRUG BENEFITS

Program Type: ❑ (Standard) $5/$10/$10

Optional Riders (Generic/Preferred Brand/Brand copay) :

❑ $10/$25/$50* ❑ $15/50%/50%*

Pharmacy Deductible Options (Waived for generic drugs): ❑ None* ❑ $50* ❑ $100 ❑ $150 ❑ $250

*Optional Riders: $10/$25/$50 & $15/50%/50% are only offered with the Pharmacy Deductible Options of None and $50.

III. ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:

Now in force and to be continued? ❑ Yes ❑ No

Currently being applied for? ❑ Yes ❑ No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

_____

2. Name of present or prior group carrier:_____

Effective date of prior coverage:_____ Cancellation/termination date:_____

Is the coverage applied for in this application replacing other group insurance? ❑ Yes ❑ No

If "Yes" give reason_____

Plan being replaced: ❑ A ❑ B ❑ C ❑ D ❑ E ❑ HMO ❑ HMO-POS ❑ Dual-Contract

❑ Other_____

3. Has your firm been uninsured for 3 or more months prior to application? ❑ Yes ❑ No

4. What forms of insurance are now or were in force?

❑ Health Benefits ❑ Prescription Drugs (Attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? ❑ Yes ❑ No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?

❑ Yes ❑ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:

A. Are any employees or dependents presently incapacitated? ❑ Yes ❑ No

B. Are any dependent children incapable of self-support due to a physical or mental disability? ❑ Yes ❑ No

III. ALL QUESTIONS MUST BE ANSWERED (continued)

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

IV. AGENT/PRODUCER INFORMATION

Broker:_____ _____
Name Code Address

Broker:_____ _____
Name Code Address

V. SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis or retired, and only full-time employees and retirees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of Oxford Health Insurance, Inc. to make or modify any request or application for insurance or to bind Oxford Health Insurance, Inc. by making any promise or representation or by giving or receiving any information. It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford Health Insurance, Inc. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at:_____on_____

_____ _____

_____

Note: *If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.*

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Oxford Health Plans®

Oxford Health Insurance, Inc.

Oxford Health Insurance, Inc.

Oxford Health Plans®

New Jersey Small Employer Certification

Mailing Address: Oxford Health Plans ▪ Attn: NJ Small Group Enrollment Dept. ▪ 14 Central Park Drive ▪ Hookset, NH 03106 ▪ 800-385-9088

For a Group Health Benefits Plan

Employer Name:

Group Policy Number:

Address:

Street

City State Zip Code

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week

P: Part-time employee who works less than 25 hours per week

T: Temporary employee

I: Independent Contractor

D: Totally Disabled employee

C: Continuee under state or federal law

U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Gender	Date of Birth
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

If additional space is needed, attach a separate sheet.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation

All Questions Must Be Answered

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay. An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total Number of Eligible Employees _____

Total Number of Eligible Employees applying/enrolling for health benefits coverage _____

Total Number of Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total Number of Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total Number of Employees in an ineligibile class or classes

Is your firm subject to Working Aged Provisions (TEFRA / DEFRA)? ❑ Yes ❑ No

Is your firm subject to the requirements of COBRA? ❑ Yes ❑ No

CERTIFICATION

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that the information provided to Oxford Health Insurance, Inc. is true and complete. I understand that if the above information is not complete or is not provided to Oxford Health Insurance, Inc. in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

_____

Signature of Officer, Partner or Owner *Title* *Date*

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness *Date*

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

_____

Signature of Officer, Partner or Owner *Title* *Date*

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness *Date*

Oxford Health Insurance, Inc.

Oxford Health Plans®

New Jersey Small Group Employer Benefits Enrollment Form and Pre-Existing Conditions Statement

Mailing Address: Oxford Health Plans ▪ PO Box 7085 ▪ Bridgeport, CT 06601-7085 ▪ 800-385-9088

Please print all information, using ink.

Policyholder (Full Legal Name of Company):

Policy Number:

Policyholder Address:

Street

City State Zip Code

SECTION I: EMPLOYEE INFORMATION

Name:

Last First Middle Initial

Telephone Number:

Home Work

Best place to call during the day: ❑ Home ❑ Work

Home Address:

Street

City State Zip Code

Occupation:

Title:

Date of Employment:_____
month/day/year

Hours worked per week:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Are you a resident of the state of New Jersey? ❑ Yes ❑ No

Do you maintain a residency in another state? ❑ Yes ❑ No

If "Yes", name the state _____

How much time do you spend there each year? _____

Reason for Completion of This Form *(Please check all appropriate boxes)*

❑ I am an employee of an organization which is applying for coverage

❑ I am now eligible for coverage

- ❑ I had no previous coverage during the past 90 days
- ❑ I had previous coverage during the past 90 days

  Name of previous carrier _____ Plan Number _____

  Effective Date: _____ Termination Date: _____
- ❑ I previously refused/waived coverage
- ❑ I am enrolling for coverage during my employer's open enrollment period. Open enrollment date: _____
- ❑ I am continuing under _____ Federal Law (COBRA) or _____ State Law

  Qualifying Event: _____ Date Continuation began: _____

  Continuation applies to: _____ Employee Only _____ Employee and Eligible Dependents
- ❑ I am continuing under a total disability extension (Attach proof of disability)
- ❑ I am terminating coverage for myself and all dependents
- ❑ I am adding (deleting) dependent(s)
- ❑ Other (specify) _____

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.

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered:

Full Name (Last, First, Middle Initial)	**Add**	**Sex**	**Social Security No.**	**Birthdate**
Employee				
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

Attach a separate sheet to list additional children. Attach proof if full-time student. Attach proof of disability.

SECTION II: CONTINUED

3. Do any of the dependents listed above live at an address other than the Home address given above?

❑ Yes ❑ No

If "Yes", name the dependent(s) and provide the address(es). _____

_____

_____

Explain the circumstances. _____

4. If any dependent's last name differs from yours, explain the circumstances.

_____

5. Are any of the dependents listed above confined in a facility or at home, due to a medical reason?

❑ Yes ❑ No

If "Yes", name the dependent(s), and the place and reason for confinement. _____

_____

_____

6. Indicate whether any person to be covered is enrolled under Medicare, Parts A and/or B.

	Part A		Part B		Medicare I.D. Number
Employee	❑ Yes	❑ No	❑ Yes	❑ No	_____
Spouse	❑ Yes	❑ No	❑ Yes	❑ No	_____
Child (give name) _____	❑ Yes	❑ No	❑ Yes	❑ No	_____

7. Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?

❑ Auto ❑ Medical

8. Are you, or any person to be covered, eligible for other health coverage?

(i.e., employer sponsored group coverage,Medicare,Medicaid) ❑ Yes ❑ No

If "Yes", indicate the name(s) of the person(s), the name(s) of the carrier(s), the policy number(s) and the type(s) of coverage.

_____

_____

9. Are you replacing existing coverage? ❑ Yes ❑ No

If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the names(s) of the persons covered by the policy. _____

_____

10. Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? ❑ Yes ❑ No

If "Yes", attach the Certificate of Group Health Plan Coverage

Please note **that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the pre-existing conditions limitation, if applicable.**

SECTION III: PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 180 days. This limitation of benefits, services and supplies applies only to employer groups with 2 - 5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
a.	Alcoholism or Drug Abuse	❑	❑
b.	Arthritis	❑	❑
c.	Blood Disorder	❑	❑
d.	Back or Neck Disorder, Injury or Pain	❑	❑
e.	Cancer or Tumors	❑	❑
f.	Diabetes	❑	❑
g.	Gastro or Intestinal Disorder	❑	❑
h.	Heart Disorder or Condition or Chest Pains	❑	❑
i.	High Blood Pressure	❑	❑
j.	Kidney or Liver Disorder	❑	❑
k.	Lung or Respiratory Disorder	❑	❑
l.	Mental or Nervous Disorder	❑	❑
m.	Paralysis, Stroke or Epilepsy	❑	❑

2. During the past 6 months, have you or any dependent to be covered:

a.	been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	❑	❑
b.	been advised to have treatment or surgery or testing that has not been done?	❑	❑
c.	been admitted to a hospital or other health care facility as an inpatient?	❑	❑
d.	taken prescribed medication(s)?	❑	❑

Please give details of any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers.The separate sheet should be signed and dated.

Question Number and Letter	Name of Person	Condition	Duration of Symptoms, Treatment, Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

SECTION IV: HEALTH CARE SECTION

(If you are enrolling in the Liberty Plan PPO do not complete this section)

Full Name (Last, First, Middle Initial)	Primary Care Physician	Oxford ID #	OB/GYN	Oxford ID #
Employee				
Spouse				
Child				
Child				
Child				
Child				

NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Woman over the age of 16 must also select a OB/GYN.

Plan Selection: _____

SECTION V: DECLARATION AND AUTHORIZATION

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information, shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a. the coverage applied for will not take effect unless:
   - after review of this Enrollment Form, Oxford Health Insurance, Inc. (OHI) accepts it;
   - the first premium has been paid to Oxford Health Insurance, Inc.; and

b. no person, except an officer of OHI has authority to: determine whether certificate shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form; or any of OHI's requirements; to bind OHI by any statement or promise pertaining to any certificate to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c. the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to OHI.

d. OHI does not pay benefits for charges, or provide services or supplies related to a pre-existing condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the pre-existing conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

Unless I request otherwise in writing, I understand that by signing below when I file a claim, OHI may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within OHI's service area. I understand that if I omit or falsify any statement on this enrollment form, OHI can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, OHI will assist the person in obtaining a certificate from the prior plan or issuer.

SECTION V: CONTINUED

AUTHORIZATION

1. I authorize the sources stated below to give to OHI, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment; other health coverage; and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which OHI has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

(Date Signed) (Signature of Employee)

(Date Signed) (Signature of Spouse, if providing information on the pre-existing conditions statement)

(Date Signed) (Signature of Child Who is age 18 or older, if providing information on the pre-existing conditions statement)

Oxford Health Insurance, Inc.

Oxford Health Plans®

New Jersey Small Employer Health Benefits Waiver of Coverage

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 ▪ 800-385-9088

Group Policy Number:

Policyholder Name:

Employee Name:

Last First Middle Initial

Social Security Number:

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 Oxford Health Insurance, Inc. I *refuse* the following:

- ❑ Employee, Spouse and Child(ren) coverage
- ❑ Spouse coverage
- ❑ Child(ren) coverage

Reason for Refusal (Please check all appropriate lines.)

- ❑ other Group Health Plan sponsored by this employer
- ❑ other Group Health Plan sponsored by my spouse's employer
- ❑ other Group Health Plan sponsored by another organization
- ❑ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name:_____ Policyholder Name:_____

Carrier: _____ Carrier: _____

Policy Number: _____ Policy Number: _____

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.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

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 Pre-Existing Conditions Statement, and coverage may be subject to a pre-existing conditions exclusion.

_____

Signature of Employee Date

_____

Signature of Witness Date