

## Healthfirst Insurance Company, Inc. Small Group Waiver of Coverage

## Mailing Address:

Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007

Broker Services: 1-855-456-3668 Employer Services: 1-855-949-3668

Employer Services: 1-855-949-3668		
Section 1   Employee Informa	ation	
Company Name:	Employee Name:	
Date of Birth:	/ Date of Employment:	
Section 2   Waiver of Coverage	ge	
Please complete the below if medical/eligible family members.	dental coverage is declined or refused by ar	n eligible employee and/or their
1. Medical coverage declined for:	Reason for declining coverage:	
Myself	group coverage	DBRA coverage dividual coverage — or Off Exchange/Marketplace surance through another job ICARE military coverage coverage onot want her
marked as waiving coverage in Section myself, if I am waiving) may not enroll Special Enrollment Period (SEP). For an or group health coverage, I may in the in this plan, provided that I request enrolled to loss of eligibility or an employer other coverage was Medicaid, Child H result of marriage, birth, adoption, or provided that I request enrollment with	portunity to enroll, but do not wish to make in 2. By waiving coverage, I recognize that the until my group's anniversary, unless the wayone whose coverage I have waived because future be qualified for a SEP and be able to rollment within 30 days after the other cover's ceasing to contribute toward that other covered that other covered the plus, or The Essential Plan). In additional placement for adoption, I may be able to enthin 30 days of any of the aforementioned expenses.	nose individuals (including iving individual qualifies for a se of other healthcare coverage enroll the waived individuals rage of the individual(s) ends coverage (within 60 days if the n, if I have a new dependent as roll myself and my dependents,
Please Provide		I
Employee Signature	Employee Email Address	Date (MM/DD/YYYY)
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