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New York
Employee Waiver Form

Instructions: You, the employee, must complete this waiver. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Information Provided by Your Employer (to be completed by the *employer*)

Employer Name	Employer Group No.

Section B: Employee Information

First Name	M.I.	Last Name	
Social Security No.		Gender ☐ Male ☐ Female	Date of Birth (mo/day/yr)
Preferred Phone		Preferred Email	

Section C: Waiver / Declining Coverage

Reason(s) for declining coverage (check all that apply):

- ☐ Covered by a spouse's/domestic partner's coverage
- ☐ Covered by parent's/guardian's group coverage
- ☐ Enrolled in individual insurance
- ☐ Enrolled in Medicare, Medicaid or VA coverage
- ☐ Other — Please explain: ____________________

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- ☐ I elect to not have coverage

Other coverage information:

Carrier: ____________________

Policy Number: ____________________

Medicare / Medicaid / VA Coverage info:

☐ Medicare ☐ Medicaid ☐ VA Coverage

Policy Number: ____________________

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. **BY WAIVING GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL PLAN UNLESS I QUALIFY FOR SPECIAL OPEN ENROLLMENT.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here **only** if you are **declining** coverage:

Signature of Applicant	Printed Name	Date (mo/day/yr)

Note: Oscar reserves the right to collect and review supporting documentation.