AmeriHealth NEW JERSEY

Health insurance that pays.SM

# Health Benefits Waiver of Coverage

AmeriHealth New Jersey
259 Prospect Plains Rd, Building M
Cranbury, NJ 08512

| | |
|---|---|
| GROUP NAME | |
| GROUP POLICY # | |
| EMPLOYEE NAME (Last, First, MI): | |
| SOCIAL SECURITY # | |
| DATE OF BIRTH | ____/____/____ |
| DATE OF HIRE | ____/____/____ |
| 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 AmeriHealth New Jersey.**

**I REFUSE the following:**

- ☐ Employee, Spouse and Child(ren) Coverage
- ☐ Spouse Coverage
- ☐ Child(ren) Coverage

**Reasons for Refusal (Please indicate all that apply.)**

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ other reasons - please explain: _____

Please provide name of carrier and policy number: _____

**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.**

Signature of Employee:

Date: ____/____/____

Signature of Witness:

Date: ____/____/____