



4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 801-442-5038/800-538-5038 www.selecthealth.org

Waiver Form Small Employer

Company Name _____ Group# _____

Last Name _____ First _____ Initial _____

Social Security# _____ Date Hired _____

A. WAIVING MEDICAL COVERAGE INFORMATION

Reason for waiving medical coverage:

I currently have medical coverage elsewhere.

Policyholder's Name _____ Relationship to Policyholder _____

Medical Carrier _____ Policy# _____ Policy Type Group Individual

I do not wish to purchase medical insurance at this time (subject to employer participation requirements; please continue to sections C and D.)

B. WAIVING DENTAL COVERAGE INFORMATION

Reason for waiving dental coverage:

I currently have dental coverage elsewhere.

Policyholder's Name _____ Relationship to Policyholder _____

Dental Carrier _____ Policy# _____ Policy Type Group Individual

I do not wish to purchase dental insurance at this time (subject to employer participation requirements; please continue to sections C and D.)

C. HEALTH INFORMATION

Y N 1. Have you and/or your dependent(s) had any medical condition(s) or treatment in the past 24 months requiring medical care or hospitalization in the amount of \$5,000 or more?

Y N 2. Are you or your spouse pregnant?

Y N 3. Are you and/or your dependent(s) anticipating surgery or have you had surgery recommended in the past 24 months which has not been performed?

Y N 4. Are you and/or your dependent(s) eligible for Medicaid?

Y N 5. To your knowledge, have you and/or your dependent(s) ever been denied other health or life insurance or been given a modified or rated policy?

For all "YES" answers, give complete details below.

D. EMPLOYEE SIGNATURE

I hereby decline to apply for coverage in the Group Health Benefit Plan provided through my employer. The benefits of the plan have been thoroughly explained to me. I understand that if I waive coverage for myself, my dependent(s) are also not eligible for coverage with SelectHealth/SelectHealth Benefit Assurance Company.

NOTE: You and/or your dependent(s) may not be eligible for coverage in this program until the next annual open enrollment period. If you do enroll at a later time, you may be subject to an 18-month pre-existing condition waiting period unless you experience a special enrollment event (i.e., involuntary loss of other coverage, marriage, birth, adoption, or placement for adoption). After completing this form, return by faxing to **801-442-3698**.

Employee's Signature _____ Date _____