

**Small Employer Health Benefits
Waiver of Coverage**

CIGNA HealthCare



GROUP POLICY NO.		POLICYHOLDER NAME	
EMPLOYEE NAME (Last, First, M.I.)			SOCIAL SECURITY #
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF EMPLOYMENT	DATE OF BIRTH
<p>I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by CIGNA. I <i>refuse</i> the following:</p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Employee, Spouse and Child(ren) coverage</p> <p><input type="checkbox"/> Spouse coverage</p> <p><input type="checkbox"/> Child(ren) coverage</p> <p><i>Reason for Refusal (Please check all appropriate boxes.)</i></p> <p><input type="checkbox"/> Other group coverage sponsored by my employer</p> <p><input type="checkbox"/> Other group coverage sponsored by my spouse's employer</p> <p><input type="checkbox"/> Other group coverage sponsored by another organization</p> <p><input type="checkbox"/> Other reasons (please explain) _____</p> <p>_____</p> <p>Please provide name of carrier and policy number: _____</p> <p>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 Health Statement, and coverage may be subject to a preexisting conditions exclusion.</p>			
SIGNATURE OF EMPLOYEE			DATE
SIGNATURE OF WITNESS			DATE