Oxford Health Insurance, Inc.

New York Health Benefits Waiver of Coverage

Mailing Address: Enrollment Dept. ■ 14 Central Park Drive ■ Hookset, NH 03106 ■ 1-888-201-4216 ■ www.oxfordhealth.com

Group Name: _____

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in this plan of group health benefits offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

❑ I have other coverage from:

- ❑ My spouse's employer
- ❑ Medicare
- ❑ Medicaid
- ❑ Veteran's Administration
- ❑ Union health plan
- ❑ Another carrier's group health plan sponsored by this employer
- ❑ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of carrier Policy number

❑ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

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 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 $5,000 dollars and the stated value of the claim for each violation. Any material misrepresentation within this waiver may subject the group to termination.

Signature of Employee Date

Signature of Benefits Administrator Date