

SMALL EMPLOYER WAIVER FORM

EMPLOYEE INFORMATION (Please print)

Employee Name: _____

Employer: _____

WAIVER INFORMATION

I understand that I am eligible to participate in the group health plan offered through my employer and have been given the opportunity to do so. I **DO NOT** want coverage. I am declining coverage at this time due to the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> I currently have coverage elsewhere | <input type="checkbox"/> Covered by Medicare | <input type="checkbox"/> Individual policy |
| <input type="checkbox"/> Covered by Medicaid | <input type="checkbox"/> Group continuation coverage (COBRA) | <input type="checkbox"/> Other |

CURRENT HEALTH INSURANCE INFORMATION (This section must be completed)

Policy Holder's Name: _____ Relationship to Policy Holder: _____

Insurance Carrier: _____

Policy Number: _____ Effective Date: _____

Policy type: Individual Group Employer Name: _____

HEALTH INFORMATION (If you answer "Yes" to any question below, please explain in space provided.)

1. Have you or any dependent(s) had any medical conditions or treatment in the past 24 months requiring medical care or hospitalization in the amount of \$5,000 or more? If so, for what condition(s)? _____ Yes No
2. Are you or any dependent(s) currently pregnant or suspect you/they might be pregnant? If yes, due date? _____ Yes No
3. Are you or any dependent(s) anticipating hospitalization or surgery or have you or any dependent(s) had hospitalization or surgery recommended which has not been performed? If so, for what condition(s)? _____ Yes No
4. Has anyone taken prescription medication for more than two weeks in the past 12 months? If so, please list names of medication(s) and condition(s). _____ Yes No

SIGNATURE (This form must be signed.)

I UNDERSTAND that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage in this program until the next open enrollment period, which is established by my employer and Altius Health Plans. I also understand that unless I am declining enrollment for myself and my dependent(s) (including my spouse) because of other health insurance coverage, I may be subject to a pre-existing condition waiting period of up to 12 months, as specified by the plan. If I am waiving because I have other insurance, I realize that I may in the future be able to enroll myself and any dependent(s) in the plan, provided that I request enrollment within (30) days after my other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within thirty (30) day after such marriage, birth, adoption, or placement for adoption.

Employee Signature: _____ Date Signed: _____