UnitedHealthcare®
Oxford

New Jersey
Small Employer Health Benefits Waiver of Coverage

Mailing Address: P.O. Box 29142, Hot Springs, AR 71903 800-385-9088

Group Policy Number:

Policyholder Name:

Employee Name:

Last First Middle Initial

Social Security Number:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____

Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Oxford Health Plans (NJ), Inc./Oxford Health Insurance, Inc. I refuse the following:

☐ Employee, Spouse and Child(ren) coverage
☐ Child(ren) coverage
☐ Spouse coverage

Reason for Refusal (Please check all appropriate lines.)

☐ Other Group Health Plan sponsored by this employer
☐ Other Group Health Plan sponsored by my spouse's employer
☐ Other Group Health Plan sponsored by another organization
☐ Other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name:_____
Carrier: _____
Policy Number: _____

Policyholder Name:_____
Carrier: _____
Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 90 days after the marriage, birth, adoption, or placement for adoption.

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