selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

selecthealth℠
BENEFIT ASSURANCE COMPANY

4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 1-801-442-5038/1-800-538-5038 www.selecthealth.org

Small Employer Products
Waiver Form

Company Name _____ Group# _____ Social Security# _____

Last Name_____First _____ Initial _____

I. Waiving Coverage Information

I am waiving coverage for:

❑ Myself only ❑ My dependent(s) only ❑ Myself and my dependent(s)

Reason for waiving coverage:

❑ I currently have coverage elsewhere (if you have group coverage through a spouse or parent plan only, please continue to sections II., III., and IV.).

❑ I do not wish to purchase health insurance at this time (subject to employer participation requirements; please continue to sections III. and IV.).

II. Coverage Information

Policyholder's Name _____ Relationship to Policyholder _____

Carrier _____ Policy#_____ Policy Type ❑ Group ❑ Individual

III. 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 had surgery recommended 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.

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IV. Employee Signature

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

NOTE: You and/or your dependent(s) may not again be eligible for coverage in this program until the next annual open enrollment period, which is established by your employer and SelectHealth. You may be subject to an eighteen (18) month pre-existing condition waiting period unless you are declining enrollment for yourself and your dependent(s) (including your spouse) because of other health insurance coverage. In the future, you may be able to enroll yourself on the Plan due to a special enrollment event (i.e., involuntary loss of other coverage, marriage, birth, adoption, or placement for adoption) provided you request enrollment within 31 days of the special enrollment event and submit applicable documentation. In addition, if due to a special enrollment event you acquire a new dependent(s) as a result of marriage, birth, adoption, or placement for adoption, you may **only** enroll yourself and the newly acquired dependent(s). **After completing this form, return by faxing to 1-801-442-3698.**

Employee's Signature _____ Date _____