

Waiver of Coverage(s)



The PerfectHealth Insurance Company
 55 Water Street 5th Floor
 New York, NY 10041

Employer Name _____
 (please print)

Group No. _____

I hereby certify that I have been given the opportunity to apply for the available group health benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) elect not to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent or health carrier, into waiving this coverage, but elected of my (our) own accord to waive coverage.

Late Enrollment

I understand that if I and/or my dependent(s) desire to apply for such coverage at a future date, and I and/or my dependent(s) am/are deemed to be late enrollees, I/my dependent(s) may be subject to a preexisting conditions exclusion period which shall not exceed 18 months from the date of enrollment (subject to reduction for prior creditable coverage, as applicable).

Special Enrollment

I and/or my dependent(s) will **not** be deemed late enrollees when applying at a future date, if the following conditions are met:

1. I and/or my dependent(s) waived this coverage due to other health coverage;
2. the other health coverage was:
 - a. COBRA continuation which terminated due to maximum continuation period being reached; or
 - b. terminated as a result of loss of eligibility for that coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or termination as a result of employer contributions towards such coverage ceasing; and
3. enrollment under this coverage is requested no later than 30 days after the date of coverage in 2. a. or b. above terminated.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Name of person waiving coverage	Reason for waiving	Type of Coverage waived	Type of existing coverage/ carrier name & information
Employee			
Spouse			
Child			
Child			
Child			

(Please use an additional sheet if needed)

Employee Name _____
 Please print

Employee Signature _____

Date _____