



WAIVER OF HEALTH COVERAGE BENEFITS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED AND SIGNATURES ARE REQUIRED FROM EMPLOYEE AND EMPLOYER.

“SEE INSTRUCTIONS ON REVERSE SIDE”

EMPLOYER INFORMATION

| | | |
|-------------------|--------|------|
| Name of Employer: | | |
| Address: | | |
| City: | State: | Zip: |
| Telephone: | | |

APPLICANT / EMPLOYEE INFORMATION

| | | |
|-------------------------|-----------------------------|------|
| Last Name: | First Name: | MI: |
| Address: | | |
| City: | State: | Zip: |
| Social Security Number: | Date of Birth (mm/dd/yyyy): | |
| Date of Hire: | Job Title: | |

OTHER COVERAGE INFORMATION

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|--|
| Do you have other health benefit coverage? |
| <input type="checkbox"/> YES, If Yes, please complete below |
| <input type="checkbox"/> NO, I do not have other health insurance coverage |
| Coverage Information: |
| Name of primary person on policy: |
| Name of Employer or the Party providing health care coverage: |
| Name(s) of dependent(s) covered on policy: |
| Name of health plan provider / insurer: |
| Please attach a photocopy of your Health Plan Provider ID Card |

VALIDATION OF WAIVER OF BENEFITS

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|---|
| I understand that I have been offered group health insurance by my employer, with Hometown Health. I have elected not to enroll myself, and/or my dependent(s). I understand that if I and/or my dependent(s) decide, at some time in the future, that I (we) desire this coverage, I must wait for my employer’s “open enrollment” period, or special enrollment period due to qualifying event.(i.e.: Divorce, marriage, birth of child, death, loss of medical insurance, etc). |
| Employee Signature: _____ Date: _____ |
| Employer Signature: _____ Date: _____ |

Comments: _____

INSTRUCTIONS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED AND SIGNATURES ARE REQUIRED BY EMPLOYEE AND EMPLOYER.

Employer Information:

1. Enter company data in the appropriate Employer information areas.

Applicant / Employee Information:

1. Enter your personal data in the appropriate Applicant / Employee information areas.

Other Coverage Information:

1. Please indicate if you do or do not have other health benefit coverage.
2. Please indicate the name of both the Employer, the primary member holding this insurance coverage and the insurance carrier providing you and/or your dependents with the coverage.
3. Attach a photocopy of the Plan Provider ID card.

Validation of Waiver of Benefits:

1. Employee: Read the statement carefully, then sign and date the Waiver of Coverage Form. Please return the form to your employer.
2. Employer: Please sign form before returning to Hometown Health.