

**Aetna Small Group**

**EMPLOYEE WAIVER OF HEALTH COVERAGE OFFERED BY EMPLOYER**

All employees who are eligible for an employer sponsored group health plan must be provided the opportunity to enroll in the group health plan. Employees must be given this opportunity at the time the employee is first eligible to enroll in the group health plan offered by Aetna. This may be at the time the employee is hired, after a waiting period or at the time a new carrier takes over the group health plan. The employer's plan document dictates when an employee must be offered the group health plan. If an employee chooses not to enroll in the employer sponsored health plan, this waiver form must be completed by the employee.

Employer Name (Policyholder): \_\_\_\_\_

Employer Group Policy Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_

**I was given the opportunity to enroll in my employer's group plan offered by Aetna. I am declining enrollment for myself and any dependents.**

The reason for declining to enroll is as follows: (Please check all that apply.)

- I do not have coverage elsewhere
- I am covered by other group coverage sponsored by my employer
- I am covered by other group coverage sponsored by my spouse's employer
- I am covered by other group coverage from another source
- Other reason (s) (please explain) \_\_\_\_\_

Please provide name of insurance carrier, policy number, and effective date of your coverage.

**Aetna reserves the right to verify the information concerning other coverage.**

I understand, if I or any my dependents request to enroll in the group health plan after my initial eligibility period, I must submit an Enrollment Form, a Health Statement, and coverage may be subject to a preexisting conditions exclusion.

\_\_\_\_\_  
Signature of Employee Date

\_\_\_\_\_  
Signature of Employer Representative Date