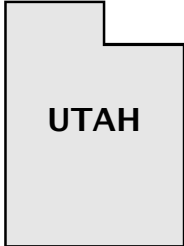




# SMALL EMPLOYER WAIVER FORM



Please Print

10421 South Jordan Gateway  
Suite 400  
South Jordan, Utah 84095

## EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_ Employer: \_\_\_\_\_

## WAIVER INFORMATION

I understand that I am eligible to participate in the group health plan offered through my employer and have been given the opportunity to do so. I DO NOT want coverage. I am declining coverage at this time due to the following:

- I currently have coverage elsewhere       Covered by Medicare       Individual policy
- Covered by Medicaid       Group continuation coverage (COBRA)       Other

## CURRENT HEALTH INSURANCE INFORMATION (This section must be completed)

Policy Holder's Name: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Type:     Individual     Group    Employer Name: \_\_\_\_\_

## HEALTH INFORMATION If you answer "Yes" to any question below, please explain in space provided.

1. Have you or any of your dependents had any medical conditions or treatment in the past 24 months requiring medical care or hospitalization in the amount of \$5,000 or more? If so, for what condition(s)? \_\_\_\_\_  Yes     No
2. Are you or any dependent(s) currently pregnant or suspect you/they might be pregnant? If yes, due date? \_\_\_\_\_  Yes     No
3. Are you or any of your dependents anticipating hospitalization or surgery or have you or any of your dependents had hospitalization or surgery recommended which has not been performed? If so, for what condition(s)? \_\_\_\_\_  Yes     No
4. Has anyone taken prescription medication for more than two weeks in the past 12 months? If so, please list names of medication(s) and condition(s). \_\_\_\_\_  Yes     No

## SIGNATURE (This form must be signed)

I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and Altius. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Requests for special enrollment or more information may be directed to Altius Health Plans, Customer Service Department, 801-323-6200 or 800-377-4161.

Employee Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_