MetroPlus Health Plan
plan ahead.
METROPLUS.ORG 1.855.809.4073

NEW YORK SMALL GROUP EMPLOYER WAIVER FORM
FOR GROUPS 1-100 FULL TIME EQUIVALENT (FTE) EMPLOYEES

TTY: 711 • MetroPlus Health Plan • 160 Water St., 3rd. Fl. • New York, NY 10038

Instructions: You, the employee, must complete this waiver. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink and submit to your employer when completed.

SECTION 1: INFORMATION PROVIDED BY YOUR EMPLOYER (TO BE COMPLETED BY EMPLOYER)

Employer Name: _____

Employer Group Number: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name: _____ First Name: _____ M.I.: ___

Social Security #(required)[1]: _____ Sex: ❑ M ❑ F

Preferred Phone: _____ Email Address: _____

[1]MetroPlus is required by the Internal Revenue Service to collect this information, but it is not required to enroll in a policy.

SECTION 3: WAIVER / DECLINING COVERAGE

Reason(s) for declining coverage (check all that apply)**:**

❑ Covered by parent's / guardian's group coverage
❑ Enrolled in individual insurance
❑ Covered by a spouse's/domestic partner's coverage
❑ Enrolled in Medicare, Medicaid or VA coverage
❑ Other (Please explain): _____

Other coverage information: ❑ Medicare ❑ Medicaid ❑ VA Coverage Policy Number: _____

Other Carrier: _____ Policy Number: _____

I acknowledge that the health insurance coverage available to me has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. BY WAIVING GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE), I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP'S MEDICAL PLAN UNLESS I QUALIFY FOR A SPECIAL ENROLLMENT PERIOD.

Fraud statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

SIGN HERE ONLY IF YOU ARE DECLINING COVERAGE:

_____ _____ ___/___/___
Printed Name *Applicant Signature* *Date*

_____ _____ ___/___/___
Administrator Signature *Printed Name* *Date*

Note: MetroPlus Health Plan reserves the right to collect and review supporting documentation.