healthfirst®
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group Waiver of Coverage

Mailing Address:
Healthfirst Insurance Company, Inc., Commercial Sales, 100 Church Street, New York, NY 10007
Broker Services: 1-855-456-3668
Employer Services: 1-855-949-3668

Section 1 | Employee Information

Company Name: _____ Employee Name: _____

Date of Birth: _____/_____/_____ Date of Employment: _____/_____/_____

Section 2 | Waiver of Coverage

Please complete the below if medical/dental coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Medical coverage declined for:	**Reason for declining coverage:**	
☐ Myself	☐ Spouse/Domestic Partner group coverage ☐ Parental coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ Another group plan provided by my employer	☐ COBRA coverage ☐ Individual coverage – On or Off Exchange/Marketplace ☐ Insurance through another job ☐ TRICARE military coverage ☐ VA coverage ☐ Do not want ☐ Other_____

Section 3 | Acknowledgment

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for, those individuals marked as waiving coverage in Section 2. By waiving coverage, I recognize that those individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). For anyone whose coverage I have waived because of other healthcare coverage or group health coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided that I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid , Child Health Plus, or The Essential Plan). 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 that I request enrollment within 30 days of any of the aforementioned events.

Please Provide

Employee Signature	Employee Email Address	Date (MM/DD/YYYY)
_____	_____	____ /____ /_____