

# BENEFITS WAIVER OPTION FORM

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_  
Work Phone \_\_\_\_\_ Date of Hire \_\_\_\_\_  
Home Phone \_\_\_\_\_

I was given the opportunity to enroll in my employer's medical and prescription plans and I am voluntarily waiving my enrollment in the following plan(s):

- MEDICAL (Check one of the following and have the bottom of the form completed in full)
- \_\_\_\_\_ Single Horizon HMO NJ coverage
  - \_\_\_\_\_ Single US Healthcare HMO coverage
  - \_\_\_\_\_ Single Horizon Blue Cross/Blue Shield of NJ coverage
  - \_\_\_\_\_ Single Horizon Healthcare HMO of PA
  - \_\_\_\_\_ Single Horizon Blue Card PPO
  - \_\_\_\_\_ Parent/Child(ren) Horizon HMO NJ coverage
  - \_\_\_\_\_ Parent/Child(ren) US Healthcare HMO coverage
  - \_\_\_\_\_ Parent/Child(ren) Horizon Blue Cross/Blue Shield of NJ coverage
  - \_\_\_\_\_ Parent/Child(ren) Horizon Healthcare HMO of PA
  - \_\_\_\_\_ Parent/Child(ren) Horizon Blue Card PPO
  - \_\_\_\_\_ Family Horizon HMO NJ coverage
  - \_\_\_\_\_ Family US Healthcare HMO coverage
  - \_\_\_\_\_ Family Horizon Blue Cross/ Blue Shield of NJ coverage
  - \_\_\_\_\_ Family Horizon Healthcare HMO of PA
  - \_\_\_\_\_ Family Horizon Blue Card PPO

- PRESCRIPTION (Check one of the following and have the bottom of the form completed in full)
- \_\_\_\_\_ Single Horizon Blue Cross/ Blue Shield of NJ Rx coverage
  - \_\_\_\_\_ Parent/ Child(ren) Horizon Blue Cross/ Blue Shield of NJ Rx coverage
  - \_\_\_\_\_ Family Horizon Blue Cross/ Blue Shield of NJ Rx coverage

I understand I must meet all the applicable deadlines in order to waive my rights to coverage or to be considered for reenrollment into the medical and/or prescription plan. I understand the rules and guidelines set forth in the Important Notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## VERIFICATION OF OTHER MEDICAL COVERAGE (To Be Completed By Other Employer's Company Representative)

This is to verify that this employee, \_\_\_\_\_, has medical coverage as indicated below. This coverage is provided by \_\_\_\_\_  
(Insurance Carrier)

Please Check Type of Coverage:

- \_\_\_\_\_ Single
- \_\_\_\_\_ Parent/Child(ren)
- \_\_\_\_\_ Husband/Wife
- \_\_\_\_\_ Family

The aforementioned information is correct to the best of my knowledge.

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Signature of Company Representative

\_\_\_\_\_  
Title / Telephone Number

\_\_\_\_\_  
Date

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