UnitedHealthcare
Oxford

New York Health Benefits Waiver of Coverage

Mailing Address: 48 Monroe Turnpike, Trumbull, CT 06611 • 1-800-889-7658 • www.oxfordhealth.com

Group Name:

Policyholder Name:

Employee Name:

Last First Middle Initial

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment:

Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Oxford Health Plans (NY), Inc. and/or Oxford Health Insurance, Inc. and I refuse coverage.

Reason for Refusal (Please check all appropriate boxes.)

- ❑ other group coverage sponsored by my employer
- ❑ other group coverage sponsored by my spouse's employer
- ❑ other group coverage sponsored by another organization
- ❑ other reasons (please explain)

Please provide name of carrier and policy number: _____

_____ Date

Signature of Employee

_____ Date

Benefits Administrator Signature

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