

Waiver of Coverage (s)

The PerfectHealth Insurance Company
 PO Box 140724
 Staten Island, New York 10314-0724



Employer Name _____
(please print)

Firm No. _____

I hereby certify that I have been given the opportunity to apply for the available group health benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) elect not to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or health carrier, into waiving this coverage, but elected of my (our) own accord to waive coverage.

Late Enrollment

I understand that if I and/or my dependent(s) desire to apply for such coverage at a future date, and I/and or my dependent(s) am/are deemed to be late enrollees, I/my dependent(s) may be subject to a preexisting conditions exclusion period which shall not exceed 18 months from the date of enrollment (subject to reduction for prior creditable coverage, as applicable).

Special Enrollment

I and/or my dependent(s) will **not** be deemed late enrollees when applying at a future date, if the following conditions are met:

1. I and/or my dependent(s) waived this coverage due to other health coverage;
2. the other health coverage was:
 - a. COBRA continuation which terminated due to maximum continuation period being reached; or
 - b. terminated as a result of loss of eligibility for that coverage (due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment); or terminated as a result of employer contributions towards such coverage ceasing; and
3. enrollment under this coverage is requested no later than 30 days after the date of coverage described in 2. a. or b. above terminated.

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 I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Name of person waiving coverage	Reason for waiving coverage	Type of coverage waived	Type of existing coverage / carrier name & information
Employee		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	
Spouse		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	
Child		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	
Child		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	
Child		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	

(Please use an additional sheet if needed)

Employee Name _____
(please print)

Employee Signature _____

Date _____