

### SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

**CUSTOMER NAME**

**EMPLOYEE NAME**  Last  First  M.I.

**SOCIAL SECURITY #**

**DATE OF BIRTH**       **DATE OF HIRE**        
Month Day Year Month Day Year

**MARITAL STATUS**  Single  Married  Widowed  Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Independence Blue Cross through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and Pennsylvania Blue Shield.

**REASON FOR REFUSAL** (Please indicate all that apply.)

- other group coverage sponsored by my employer \*
- other group coverage sponsored by my spouse's employer
- other-reasons--please explain

Notice: An offer of employer coverage will typically eliminate ACA subsidy eligibility. Refusal for "having obamacare", unless under the afford-ability rule or an exception is not a valid reason to waive. Accepting an ACA subsidy is your responsibility and you may be forced to pay it back at a later time if deemed ineligible.

\* Must meet participation guidelines, if applicable.

I understand that if I wish to enroll for any of the coverage refused, I will be required to submit an Enrollment Form.

Signature of Employee

Date

Signature of Witness

Date

