Independence Blue Cross 1901 Market Street Philadelphia, PA 19103



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

CUSTOMER NAME																
EMPLOYEE NAME			La	st								Fi	rst		N	Л.І
SOCIAL SECURITY #																
DATE OF BIRTH	Month [Day	Year		DA	TE O	F HIRE	Mor	nth	Da	ay		Yea	r		
MARITAL STATUS	☐ Single		Married		Wido	wed		Divorc	ed							
I was given the oppoinsured by Independ Co. and Pennsylvani	dence Blue	Cross th														
REASON FOR REFU	SAL (Please	e indicate	all that a	ipply.)												
other group cove	erage spons	sored by r	ny emplo	yer *												
other group cove	erage spons	sored by r	ny spous	e's em	ployer	-										
other-reasonsp	please expla	ain														
* Must meet par	ticipation gu	iidelines,	if applica	ble.												
I understand that if I Enrollment Form.	I wish to en	roll for a	ny of the	e cover	rage r	efuse	ed, I wil	l be red	quire	d to	suk	omit	an			
Signature of Employee								-	Date					_		
Signature of Witness								_	Date					_		