CareConnect℠

New York Health Benefits Waiver of Coverage

Group Name:_____

Employee Name:_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____/_____/_____

Date of Birth: _____/_____/_____

I was given the opportunity to enroll in a group health benefits plan offered by my employer and insured by North Shore-LIJ CareConnect Insurance Company, Inc., and I have chosen to refuse coverage.

Reason for Refusal

☐ Spousal Waiver (coverage sponsored by my spouse's employer)

☐ Parental Waiver (coverage sponsored by my parents)

☐ Medicaid

☐ Medicare

☐ Veteran coverage

☐ Other coverage/Exchange coverage

☐ Other reason_____

Please Provide (where applicable):

_____ _____

Name of Carrier Policy Number

_____ _____/_____/_____

Employee Signature Date

_____ _____/_____/_____

Benefits Administrator Signature Date

North Shore-LIJ CareConnect Insurance Company, Inc.
Attn: Group Enrollment
2200 Northern Boulevard, Suite 104, East Hills, NY 11548
855-706-7545 CareConnect.com