

California Employee Waiver Form

You, the employee, must complete this waiver (if eligible but declining or waiving coverage). You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink, and submit this to your employer when complete.

Section A: Information to be completed by the employer			
Employer name		Employer group number (if available)	
Section B: Employee information			
Employee first name	M.I.	Last name	
Social Security Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)
Phone number		Email address	
Section D: Waiver / declining coverage			
Reason(s) for declining coverage (please check all that apply): <input type="checkbox"/> Covered by another group's health plan <input type="checkbox"/> Covered by Medicare, Medi-Cal, or TRI-CARE coverage <input type="checkbox"/> Covered by COBRA / Cal-COBRA coverage <input type="checkbox"/> Enrolled as an individual in another health plan <input type="checkbox"/> Enrolled as a dependent in health plan through a different employer <input type="checkbox"/> I elect not to have coverage <input type="checkbox"/> Other reasons (please explain): _____		Carrier	
		Policy number	
		If you chose Medicare, Medi-Cal, or TRI-CARE for declining coverage, please specify one below: <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> TRI-CARE	
		Policy number	
Section E: General agreement			
<p>Please read this section carefully, and <u>please sign only if declining coverage</u>:</p> <p>I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. By waiving group medical coverage (unless employee and/or dependents have group medical coverage elsewhere) I acknowledge that my dependents and I may have to wait until the next open enrollment to be enrolled in this group's medical plan unless I qualify for special open enrollment.</p> <p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p> <p>If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). Please see your Evidence of Coverage or Underwriting Guidelines for more information, including the special enrollment periods. To request special enrollment, contact Oscar at 1-855-672-2784.</p>			
Applicant signature	<div style="border: 1px solid red; border-radius: 15px; padding: 2px 10px; display: inline-block;">Sign here</div>	Printed name	Date (mm/dd/yyyy)