



11 west forty-second street  
new york, ny 10036

[www.empireblue.com](http://www.empireblue.com)

## Small Group Health Benefits Waiver

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_  
Last First Middle Initial

Date of Employment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I was given the opportunity to enroll in this group health benefits plan offered by my employer and insured by Empire HealthChoice HMO, Inc, and/or Empire HealthChoice Assurance, Inc.

I refuse coverage as I currently have other group coverage sponsored by my spouse's employer.

### Please provide:

Name of Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee Date

\_\_\_\_\_  
Benefits Administrator Signature Date