Oxford Health Plans®

Insurance Waiver Form

Group Name: ____

Employee Name: ____
(PLEASE PRINT)

This is to certify that I have received an explanation of the benefits available to the employees of the above named group and that I understand what benefits are available to me as an employee. After reviewing these benefits, I have decided to waive the coverage administered by Oxford Health Plans for the reason indicated below.

Please select the appropriate reason for waiving coverage:

_______Coverage through spouse

_______Coverage through individual policy

_______Other group coverage

_______No coverage

_______Other ____
(PLEASE SPECIFY)

I understand that if I am waiving without other coverage, I will not be able to join the plan until the next open enrollment period. If I am waiving this coverage because I have other coverage elsewhere, I understand that I will have the opportunity to enroll in this plan should I no longer be eligible for the other coverage at some point in the future. I realize that Oxford will need to receive my completed and signed enrollment form along with proof of being no longer eligible for the other coverage within 31 days of losing the other coverage. If I fail to meet this deadline, I understand that I will have to wait until the next open enrollment period to enroll in this plan.

______________________________ Date: ______________________
Employee Signature

______________________________ Date: ______________________
Benefits Administrator Signature