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**CONNECTICUT  
SMALL EMPLOYER HEALTH BENEFITS  
WAIVER OF COVERAGE**

Group Policy No. \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI

Marital Status: Single Married Widowed Divorced

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

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I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Aetna, Inc. I **refuse** the following:

- Coverage for Employee, Spouse and Child(ren).
- Coverage for Spouse
- Coverage for Child(ren)

**Reason for Refusal** (Please check all appropriate boxes.)

- Other group coverage sponsored by my employer
- Other group coverage sponsored by my spouse's employer
- Other group coverage by another organization
- Other reasons (please explain) \_\_\_\_\_

Please provide name of carrier and policy number: \_\_\_\_\_

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date