REFUSAL OF HIP INSURANCE FORM

FOR SMALL BUSINESSES WITH FEWER THAN 51 ELIGIBLE EMPLOYEES

(*Please Print*)

Group Policy Number: _____

Name of Employer: _____

Employee's Name: _____
(Last, First, MI)

Social Security Number: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widower

Number of Eligible Dependent Children: _____

I was given the opportunity to enroll in a group insurance plan offered by my employer and insured by HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.
I am refusing:
(**Note:** *Benefits provided on a noncontributory basis cannot be refused.*)

HIP/HMO:	**Choice Plus:**
❑ Employee & Dependents	❑ Employee & Dependents
❑ Spouse	❑ Spouse
❑ Child(ren)	❑ Child(ren)

ANSWER IF YOU ARE REFUSING ANY COVERAGE:
Are you or your dependents now covered by any other group plan? ❑Yes ❑No

If yes,
Policyholder's Name: _____

Carrier: _____

I understand that I may be required to furnish, at my expense, EVIDENCE OF INSURABILITY satisfactory to HIP Health Plan of New York and HIP Insurance Company of New York if I later wish to enroll for any of the coverages refused.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date