



One Liberty Plaza
165 Broadway, 13th Floor
New York, NY 10006

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: _____

Signature of employee

Date

Benefits administrator signature

Date