Notice of Enrollment Period and Waiver Form

Employer Group Name: _____

If you are declining enrollment for yourself and/or dependents (including your spouse) under this plan because you have other health coverage, you may in the future be able to enroll yourself or your dependents in this plan. Your request for enrollment must be submitted to Atlantis Health Plan within 30 days after your other coverage involuntarily ends.

If you are declining coverage, please check one of the following reasons:

_____ **I am declining coverage because I have coverage through my spouse.**

_____ **I am declining coverage because I am enrolling in another coverage option offered by my employer.**

_____ **I am declining coverage because I choose not to participate. I understand that I will not be eligible to enroll in this plan until the open enrollment date.**

_____ _____

Employee Signature Date

_____

Print Name

ATLANTIS HEALTH PLAN
By Doctors. For New Yorkers.

AHP-00116
Updated 12.28.09