

Waiver of Coverage

Complete only if NOT electing Medical Associates Health Plans

I hereby elect to waive coverage offered by my Employer through Medical Associates Health Plans for myself and my dependents (if applicable) due to the following:

_____ I (and my dependents if applicable) have coverage under my spouse's group Plan.

_____ I (and my dependents if applicable) have no health insurance coverage.

_____ Other reason (please explain) _____

I understand that by waiving coverage, I will not have the opportunity to enroll under the Medical Associates Health Plans, unless certain qualifying events occur and meet State or Federal guidelines.

I certify that the answers on this application are complete and true to the best of my knowledge. I understand that any misrepresentation or fraudulent statement, as to the presence or absence of preexisting medical conditions, impairments, disease or any other submissions will void membership and right to benefits. I understand that I must report any change in health status to Medical Associates Health Plans between the date of application and the acceptance date.

Signature _____ Date _____

Notice of Individual Enrollment Period Qualification Requirements

If you are declining enrollment for yourself or your dependents (including your spouse) and you have no health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of birth, marriage, or adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the above qualifying event. Note: There will be no open enrollment period during which you can enroll under this plan when you have no health insurance coverage in place, except as stated in the event of an Individual Enrollment Period.

Notice of Preexisting Condition Limitation

Under this Plan a preexisting limitation relates to the exclusion of benefits relating to a condition that was present within the six-month period before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Preexisting Conditions will be covered for up to \$2,500.00 in payments for all conditions combined. After the maximum payment has been made, Preexisting Conditions will not be covered until the member has been covered under the Plan for 12 consecutive months.

In no event does this Preexisting Condition Limitation apply to (a) a newborn child or a child who has been adopted when properly enrolled with 31 days of the birth or adoption, (b) pregnancy.

The period that the Preexisting Condition Limitation will apply can be reduced by periods of other Creditable Coverage that the member had in place before enrolling in this Plan. Other Creditable Coverage would be coverage under another Employer Group Health Plan, Insurance Plan, Medicare, Medicaid, etc. (See subscriber agreement for completed definition). If a break in coverage of sixty-three days or more has occurred, no Period of Creditable Coverage exists that can be applied toward satisfying this Plan's preexisting condition limitation. Waiting periods do not count as Creditable Coverage nor do they count as a break in coverage. The Employer and/or Plan is required to issue you a Certificate listing prior Creditable Coverage when you terminate coverage under this Plan. If you need assistance in obtaining this Certificate, the Member Services Department of Medical Associates Health Plans can assist.

Signature _____ Date _____