



Medical Coverage Offered to Individuals and Families

Colorado - Business Groups of One Waiver of Coverage Form

The state of Colorado requires that if a **Business Group of One** is applying for Medical coverage, the carrier must accept or reject the entire family, unless the applicant waives coverage for a family member who has other medical coverage in effect. **This form is required for Colorado Business Groups of One that are applying for family coverage, but is not required if applying for KeyMed.**

Check it out - then check it off! Use the following checklist to make sure you have properly filled out this form.

- In the Family Members Listing box, fill in the names of **ALL** family members whether they are applying for coverage with Assurant Health or not. Family members include: your spouse and your dependent children through the age of 24; if they share your legal residence and are financially dependent upon you for support. The applicant must attest that all eligible family members are listed in the Family Members Listing box.
- In the Waiver Listing box, fill in the names of the family members who have other health insurance coverage in effect.
- The Primary Insured must sign the statement at the bottom agreeing to waive coverage under the Assurant Health plan for the family members indicated in the Waiver Listing box.

Family Members Listing (list ALL family members here)		
First and Last Name	Relationship	Applying for coverage with Assurant Health?
1.		<input type="checkbox"/> Yes or <input type="checkbox"/> No
If not applying for coverage with Assurant health, why?		
2.		<input type="checkbox"/> Yes or <input type="checkbox"/> No
If not applying for coverage with Assurant health, why?		
3.		<input type="checkbox"/> Yes or <input type="checkbox"/> No
If not applying for coverage with Assurant health, why?		
4.		<input type="checkbox"/> Yes or <input type="checkbox"/> No
If not applying for coverage with Assurant health, why?		
5.		<input type="checkbox"/> Yes or <input type="checkbox"/> No
If not applying for coverage with Assurant health, why?		

* If you have additional family members please attach a separate sheet. Sign and date any additional sheet.



I attest that myself and all family members are listed in the Family Members Listing.

Signature of Applicant

I attest that the family members listed below have other health insurance coverage in effect.

Waiver Listing		
First and Last Name	Name of Carrier and Type of Coverage (individual, group, short term, KeyMed, government . . .)	Effective Date of Coverage



After consideration, it is my decision to waive coverage under the Assurant Health plan for the family members indicated in the Waiver Listing above.

Signature of Applicant

Date