PREMERA | BLUE CROSS

P.O. Box 91059
Seattle, WA 98111-9159

Waiver of Coverage

1. EMPLOYEE INFORMATION

Group/employer name		Group number	
Employee name	Employee date of birth	Gender ☐ Male ☐ Female	Number of hours worked per week

2. WAIVER CONFIRMATION

This is to confirm that I decline to participate in the Premera Blue Cross program offered through my employer's group health plan as follows.

☐ I do not wish to enroll **myself**. I have other Group coverage as follows:
- ☐ CHAMPUS/Tricare
- ☐ Medicare as primary, at the request of the Medicare enrollee
- ☐ Another group health plan through my spouse or parent. Name of spouse's/parent's employer: ______________________

☐ I do not wish to enroll **myself**. I have other Individual coverage.
☐ I do not wish to enroll **myself**. I do not have other health coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have other Group coverage.
☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have other Individual coverage.
☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have coverage through Medicaid/CHIP or other state-sponsored coverage.
☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They do not have other health coverage.

*Please list the names of specific children you wish to waive if you are not enrolling all of them: ______________________

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3. EVIDENCE OF OTHER GROUP COVERAGE

Are you an employee of a small group employer (50 employees or less)? *If unknown, check with your Group Benefits Administrator to verify.*

☐ No, go to Section 4 ☐ Yes, please provide the following:

If you have declined due to having **other Group coverage for yourself**, attach one of the following to provide evidence of that other coverage.

☐ Copy of your insurance ID card from the other group coverage
☐ Copy of an Explanation of Benefits (EOB) for yourself from the other group coverage

4. EMPLOYEE SIGNATURE

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

By signing below, you understand that you will be unable to obtain coverage under your employer's group health plan until the next open enrollment period, unless you and/or your dependents qualify for enrollment under the special enrollment rules described above.

Please note: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

X	Date

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