

Waiver Form (Group Size 2 - 50)

SECTION 1 - GROUP INFORMATION	
Group Name	Group Number
SECTION 2 - EMPLOYEE INFORMATION	
Employee Name (Last, First, Middle)	
Employee Date of Hire	Employee average number of hours worked per week
Name of Dependent Waiving Coverage (Last, First, Middle)	Relationship to Employee
* If additional space is needed please attach a separate sheet of paper.	
SECTION 3 - WAIVING COVERAGE INFORMATION	
I have been offered coverage under my group's plan through Regence BlueShield of Idaho, but I am waiving coverage for the following reason:	
<input type="checkbox"/> I do not wish to enroll in group insurance coverage at this time. I understand that by not enrolling for medical/dental coverage, I hereby waive the right to medical/dental coverage for myself and any eligible dependents under the Small Employer Health Insurance Availability Act. I have been informed of and understand the consequences of refusing medical/dental coverage at this time. I also understand that request for enrollment at a later date may require waiting periods for preexisting conditions, not to exceed a twelve (12) month period.	
<input type="checkbox"/> I currently have other qualifying coverage elsewhere: Carrier _____ Policy Number _____ Policy Type: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TriCare <input type="checkbox"/> Indian Health <input type="checkbox"/> Other _____	
<p>If you are waiving coverage under this medical/dental plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may under certain circumstances be able to enroll yourself or your dependents under this plan in the future, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you waive enrollment under this medical plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under this plan, provided that you request enrollment within 60 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. However, if you voluntarily end your other coverage after waiving this coverage, you and your dependents may not be eligible to enroll in this plan until the next annual enrollment period. Please contact your Group Administrator or our Member Services Department if you require further information.</p> <p>I understand that I and/or any of my dependents will be unable to obtain coverage under my group's plan through Regence BlueShield of Idaho until the next annual enrollment period, unless I and/or my dependents qualify for a special enrollment period.</p> <p>I further certify that all information completed on this form is true, correct and complete and acknowledge that my coverage is subject to any action permissible by law, if any completed information is found to be false or incorrect.</p>	
_____ Signature of Employee	_____ Date