Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
1800 Ninth Avenue
Seattle, WA 98101

Waiver Form

SECTION 1 - GROUP INFORMATION

Group's Name	Group Number (for existing groups only)

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)

Date of Hire (mm/dd/yyyy)	Average number of hours worked per week	Waiving coverage for:
		☐ Employee ☐ Employee/Dependent(s) ☐ Dependent(s) Only

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Regence BlueShield (Regence), but I am waiving coverage for the following reason(s). **Check all that apply:**

☐ I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.

☐ I currently have medical coverage elsewhere:

Carrier _____ **Policy Number** _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

☐ I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time.

☐ I currently have dental coverage elsewhere:

Carrier _____ **Policy Number** _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

If you have checked the above for coverage elsewhere, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits).

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage (or an employer stops contributing towards other group coverage), provided that you request enrollment within 30 days after you or your dependent's other coverage ends (or employer contributions stop). In addition, if you waive enrollment under this medical/dental 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 dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I have provided these answers as part of the application process required by Regence to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

If you are using this form to terminate your existing Regence group coverage, your signature confirms that you do not (or did not) have an expectation of coverage and that you paid no premium(s) after the requested cancellation date.

▶ _____ (mm/dd/yyyy) _____

Signature of Employee — Date

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