



# Regence

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

Regence BlueCross BlueShield of Oregon  
100 SW Market Street  
PO Box 1271  
Portland, Oregon 97207-1271

## 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
Date of Hire	Average number of hours worked per week	Waiving coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Dependent(s) <input type="checkbox"/> Dependent(s) Only

### SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Oregon (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  Medicaid  TriCare  Indian Health Service

Government sponsored health plan  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  Medicaid  TriCare  Indian Health Service

Government sponsored health plan  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 under certain circumstances be able to enroll yourself or your dependent(s) 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 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. However, if you voluntarily end your other coverage after waiving this coverage, you and your dependent(s) 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.

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 further certify that all information completed on this form is true, correct and complete and acknowledge that my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

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.

Signature of Employee	Date

