



# Regence

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

Regence BlueCross BlueShield of Oregon

## Waiver Form

### SECTION 1 - GROUP INFORMATION

Group Name	Group Number
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### SECTION 2 - EMPLOYEE INFORMATION

Employee Name (Last, First, Middle)
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Employee Date of Hire	Employee average number of hours worked per week	Waiving coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Dependents <input type="checkbox"/> Dependents Only
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### SECTION 3 - WAIVING COVERAGE INFORMATION

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

- I do not wish to enroll myself and/or my dependents in my group's medical plan at this time
- I currently have medical coverage elsewhere:

Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy Type:  Group  Medicare  Medicaid  TriCare  Other \_\_\_\_\_

For Groups of 50 or Less:  Christian Scientist  Indian Health  Government sponsored health plan

- I do not wish to enroll myself and/or my dependents in my group's dental plan at this time
- I currently have dental coverage elsewhere:

Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

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 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 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.

I understand that I and/or any of my dependents will be unable to obtain coverage under my group's plan through Regence BlueCross BlueShield of Oregon until the next annual enrollment period, unless I and/or my dependents 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.

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Signature of Employee Date