

Waiver of Coverage



Employer Name: _____ Employer Phone #: _____

Location of Workplace (city): _____

I. Employee Information

Employee Instructions: Please print in black ink. Please fill out the entire form to waive coverage for you and your entire family. If you are not waiving coverage for yourself and all family members, please complete the subscriber application and indicate individual waiving of coverage.

Social Security #: _____ Job Title: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ E-mail: _____

What is the first day you worked **full time** with your present employer? ____/____/____ Hours worked per week: _____

Are you:

- a.) Single Married Divorced Widow/Widower
b.) A Retiree? Yes No
c.) On COBRA or State Continuation? Yes No If YES, start date & reason _____

II. Waiver of Coverage

WAIVER OF COVERAGE I have decided not to apply for coverage offered for Medical: Employee Entire Family
Dental: Employee Entire Family

Please check if any of the following apply:

- I am covered or will be covered under another plan that is **not** sponsored by my employer. I am not enrolled for coverage under the Health Insurance Risk Sharing Program (HIRSP).
 My dependents are covered or will be covered under another plan that is **not** sponsored by my employer. My dependents are not enrolled for coverage under the Health Insurance Risk Sharing Program (HIRSP).
 I am covered by another plan that is sponsored by my employer.
 Other: _____

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan at a later date if I, or my dependents, lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I understand that I must request

enrollment within 31 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself and my dependents. However, I must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request a special enrollment or obtain more information, please contact our Customer Service Department.

Signature of Employee: _____ Date Signed: _____

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