An Independent Licensee of the Blue Cross Blue Shield Association

Employee Waiver Form

Group Name: ______________________________

BCBSM – Group Number/Suffix ______________ BCN – Group ID, Class ID, Sub Group ID ______________

Please check the appropriate box below and provide all applicable information:

Employee Name: ______________________________
(Please Print)

I am eligible for group health coverage offered by this employer.

- ❑ I am waiving BCN coverage because I am currently enrolled in BCBSM.
- ❑ I am waiving BCBSM coverage because I am currently enrolled in BCN.
- ❑ I have other coverage and am enrolled in a group health program offered by this employer (other than BCBSM or BCN). The information for this coverage is as follows:

Carrier Name	Policy/Contract Number

I hereby waive BCBSM and BCN coverage offered by this employer for the following reason:

- ❑ I have my own individual coverage. The information for this coverage is as follows:

Carrier Name	Policy/Contract Number

☐ **Please check this box if this employer provides any contribution or reimbursement for this coverage.**

- ❑ I am covered under another group health plan or dental plan not offered by this employer (spouse, self, parent, etc.). The information for this coverage is as follows:

Carrier Name	Policy/Contract Number
Policyholder Name	Relationship to Employee

- ❑ I was not offered health care coverage or dental coverage by this employer.
- ❑ I do not want the group health care coverage or dental coverage offered through this employer.

Explain reason: ______________________________

The information printed above is true and accurate to the best of my knowledge.

Employee Signature	Date
Employer Signature	Date