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

Regence BlueShield of Idaho
1602 21st Avenue
PO Box 1106
Lewiston, Idaho 83501

Waiver Form
(Group Size 2 - 50)

SECTION 1 - GROUP INFORMATION

Group Name	Group Number

SECTION 2 - EMPLOYEE INFORMATION

Employee Name (Last, First, Middle)

Employee Date of Hire	Employee average number of hours worked per week	Waiving coverage for: ☐ Employee ☐ Employee/Dependents ☐ Dependents Only

Name of Dependent Waiving Coverage (Last, First, Middle)	Relationship to Employee

* If additional space is needed please attach a separate sheet of paper.

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Regence BlueShield of Idaho, but I am waiving coverage for the following reason:

☐ I do not wish to enroll myself and/or my dependents in group insurance coverage at this time.

I understand that by not enrolling for medical/dental coverage, I hereby waive the right to medical/dental coverage for myself and any eligible dependents under the Small Employer Health Insurance Availability Act. I have been informed of and understand the consequences of refusing medical/dental coverage at this time. I also understand that request for enrollment at a later date may require waiting periods for preexisting conditions, not to exceed a twelve (12) month period.

☐ I currently have other qualifying coverage elsewhere:

Carrier ______________________ **Policy Number** ______________________

Policy Type: ☐Group ☐Individual ☐Medicare ☐Medicaid ☐TriCare ☐Indian Health

☐Other ______________________

If you are waiving coverage under this medical/dental plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents under this plan if you or your dependents lose eligibility for that other coverage (or an employer stops contributing towards that other coverage), provided that you request enrollment within 30 days after your or your dependents' 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 dependents under this plan, provided that you request enrollment within 60 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 dependents will be unable to obtain coverage under my group's plan through Regence BlueShield of Idaho until the next annual enrollment period, unless I and/or my dependents qualify for a special enrollment period.

I have provided these answers as part of the application procedure required by the Issuer to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield of Idaho will rely on each answer in making coverage and rating determinations.

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 BlueShield of Idaho in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

______________________ Signature of Employee

______________________ Date