Blue Cross Blue Shield of Massachusetts Waiver

Company Name: ____

Employee's Name: ____

Date of Birth: ____

Medical

☐ I waive my employer's group **Medical** insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

☐ I am covered as a spouse or dependant under another group **Medical** plan.

☐ I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer Name: ____

Insurance Company: ____

☐ I am not covered by another **Medical** insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation): ___________________________________

Dental

☐ I waive my employer's group **Dental** insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

☐ I am covered as a spouse or dependant under another group **Dental** plan.

☐ I am covered by non-group, Veterans program or a secondary employer.

Employer Name: ____

Insurance Company: ____

☐ I am not covered by another **Dental** insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation):___________________________________

I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature: _______________________________________ Date: _______________________________________

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Blue Cross Blue Shield of Massachusetts has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _______________________________________ Date: _______________________________________

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