



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 51+)

SECTION 1 - GROUP INFORMATION

Group's Name
Group Number (for existing groups only)

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle)
Social Security Number
Date of Birth
Date of Hire
Average number of hours worked per week
Waiving coverage for:
Employee
Employee/Dependent(s)
Dependent(s) Only

SECTION 3 - WAIVING COVERAGE INFORMATION

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

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

Carrier
Policy Number
Policy Type: Group, Individual, Medicare, Medicaid, TriCare, Indian Health Service, Other

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

Carrier
Policy Number
Policy Type: Group, Individual, Medicare, Medicaid, TriCare, Indian Health Service, Other

If you have checked the above for coverage elsewhere, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or similar proof such as a current EOB (Explanation of Benefits).

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

I have provided these answers as part of the application process 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 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 in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

If you are using this form to terminate your existing Regence group coverage, your signature confirms that you do not (or did not) have an expectation of coverage and that you paid no premium(s) after the requested cancellation date.

Signature of Employee
Date

