Regence

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

Regence BlueCross BlueShield of Oregon
100 SW Market Street
PO Box 1271
Portland, Oregon 97207-1271

Waiver Form

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 (mm/dd/yyyy)

Date of Hire (mm/dd/yyyy)	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 BlueCross BlueShield of Oregon (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** _____

Member ID Number _____

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

☐ Government sponsored health plan ☐ 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** _____

Member ID Number _____

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

☐ Government sponsored health plan ☐ Other _____

If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier, Policy Number or Member ID Number, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or 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 insurance, 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 that other coverage provided that you request enrollment within 30 days after your other coverage ends. In addition, if you waive enrollment under this medical 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 30 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 further certify that all information completed on this form is true, correct and complete and acknowledge that my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

▶ _____ (mm/dd/yyyy) _____

Signature of Employee — Date

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