Blue Cross Blue Shield of Massachusetts

Waiver of Group Coverage

Company Name: _____

Employee's Name: _____ Date of Birth _____

Please Check One:

❑ I waive my employer's group health insurance coverage for myself and my dependents (if any).

❑ I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents.

Reason for Waiving Coverage – Please Check One:

❑ Covered through spouse's employer.

Employer Name: _____

Insurance Company: _____

❑ Other reason (explain): _____

_____

As a result, 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 only within 30 days of involuntary loss of other group, coverage or, at the time of my employer's annual open enrollment.

Employee Signature: _____ Date: _____

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#39988B (6/03)