WAIVER OF ENROLLMENT

BlueCross BlueShield of Kansas
An Independent Licensee of the Blue Cross and Blue Shield Association.

The group insurance program has been offered to me, and I am waiving my right to participate because:

HEALTH

☐ I am covered by my spouse or parent's insurance program which includes:

☐ Health Only ☐ Dental Only ☐ Health and Dental

Spouse or Parent's Name: _____ Social Security #: _____

Place of Employment: _____

Name of Insurance Company: _____

☐ I do not desire to enroll in Blue Cross and Blue Shield of Kansas coverage at this time and have no other insurance.

☐ Other (i.e. Medicaid, CHAMPUS, Medicare): _____

Notice of Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 63 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 63 days after the marriage, birth, adoption, or placement for adoption. Check with your group leader for details.

DENTAL

☐ I do not desire to enroll in Blue Cross and Blue Shield of Kansas Dental at this time, and have no other Dental Insurance.

Restrictions may apply if you do not enroll at your first opportunity.

Employee Signature: _____ Employee Name (please print): _____

Employer Name: _____ Group #: _____ Date: _____