Capital BlueCross

P.O. Box 773132
Harrisburg, PA 17177-3132

WAIVER OF GROUP HEALTH INSURANCE COVERAGE

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

ALL SHADED AREAS MUST BE COMPLETED

1. APPLICANT INFORMATION

APPLICANT'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.
SPOUSE'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.

2. VALIDATION STATEMENT

I hereby certify that I have been given the opportunity to participate in the group health insurance plan provided by my employer through Capital BlueCross and have been informed of the consequences of not enrolling in such plan at this time. I understand that if I reject the group health plan on behalf of myself and/or my spouse or other eligible dependents, the group health plan will not provide any benefits on behalf of those individuals for whom I have waived coverage. With this knowledge, I decline to enroll:

☐ MYSELF ☐ MY SPOUSE ☐ MY ELIGIBLE DEPENDENTS

3. OTHER INSURANCE INFORMATION

Complete the following information for applicant and/or spouse and/or other eligible dependent(s) waiving coverage because they are currently covered for health care services with another health care plan. A copy of the current health insurance ID card is required for all employees waiving coverage or enrolled/enrolling on their spouse's health coverage for any group having 50 or fewer contracts.

NAME OF CONTRACT HOLDER	NAME AND LOCATION (STATE) OF HEALTH CARE PLAN/INSURANCE CO.	POLICY/IDENTIFICATION NO.

4. WAIVER INFORMATION

NAME (LAST) (FIRST) (MI)	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO.
a. APPLICANT		
b. SPOUSE		
c. ELIGIBLE DEPENDENT		
d. ELIGIBLE DEPENDENT		
e. ELIGIBLE DEPENDENT		
f. ELIGIBLE DEPENDENT		

5. COVERAGE BEING WAIVED (CHECK (√) COVERAGE BEING WAIVED)

Trad.	Comp	PPO	PPO+	POS	HMO	Senior	Dental	Vision	Drug

6. STATEMENT AUTHORIZATION

I understand that in the event that I decide to apply for this coverage at a later date, I and/or my spouse and/or any other eligible dependents may be subject to certain policy limitations.

EMPLOYEE SIGNATURE	DATE
NAME OF GROUP	GROUP NO.

ORIGINAL — Capital BlueCross 1st COPY — Applicant Copy 2nd COPY — Group Copy

DID YOU INCLUDE COPIES OF YOUR ID CARD?