



An Independent Licensee of the Blue Cross and Blue Shield Association

Camp Hill, Pennsylvania 17089

## WAIVER OF INSURANCE COVERAGE

**A. APPLICANT INFORMATION** (Please Print):

Employee Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Hire Date: \_\_\_\_\_

**B. OTHER INSURANCE INFORMATION:**

I elect to waive health care coverage offered by my employer through Highmark Blue Shield. I currently:

- Do not have health coverage under any health plan.
- Do have health coverage through (please complete the following information):

CONTRACT HOLDER NAME	
NAME OF HEALTH CARE PLAN/INSURER	
GROUP NUMBER	SUBSCRIBER ID NUMBER
RELATIONSHIP OF CONTRACT HOLDER TO YOU	

▶ I decline coverage for the following individuals. Please check (✓) types of coverage being waived for each individual.

				COVERAGE WAIVED		
	LAST NAME	FIRST NAME	MI	MEDICAL	DRUG	VISION
EMPLOYEE						
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

**C. VALIDATION/AUTHORIZATION STATEMENT:**

▶ I hereby certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer through Highmark Blue Shield and/or Subsidiaries. I understand that in the event that I decide to apply for this coverage at a later date, not related to a lifestyle change, I and/or any other eligible dependents **may be** subject to certain waiting periods involving any pre-existing conditions.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_