SG-DC

Blue Cross Blue Shield Blue Care Network of Michigan

EMPLOYEE WAIVER FORM

Company name: Access Point - Office (Please print) Employee ID

Employee Name: _____ (Please print)

I understand that by waiving coverage I will not be eligible to enroll until the groups next open enrollment and I acknowledge that I have been offered insurance and an enrollment packet.

Please check the appropriate box below and provide all applicable information:

If your employer offers multiple choices of health insurance plans, please complete the following section:

☐ I am waiving BCN coverage from my employer because I am currently enrolled in BCBSM.

BCBSM Group Number _____

☐ I am waiving BCBSM coverage from my employer because I am currently enrolled in BCN.

BCN Group Number _____

☐ I have coverage other than BCBSM or BCN, offered by my employer.

Carrier Name: _____

Policy/Contract Number: _____

If you are waiving coverage offered by your employer for another reason, please complete the following section:

☐ I have my own individual coverage:

Carrier Name:_____ Policy/Contract Number: _____

☐ **Please check this box if this employer provides any contribution or reimbursement for this coverage.**

☐ I am covered under another group health plan, vision plan or dental plan not offered by this employer through spouse self parent other

Carrier Name: _____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

☐ I was not offered vision coverage or dental coverage by this employer.

☐ I do not want coverage offered through this employer (Reason must be provided):_____

_____

The information provided above is true and accurate to the best of my knowledge.

Employee signature	Job Title	Date
Employer signature	Job Title	Date