

Waiver of Enrollment

for group use only



Section 1 – Health/Rx

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

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

Health/Rx only Dental only Health/Rx and Dental

Spouse or Parent Name

Plan ID Number

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 (please specify) _____

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 following a triggering event. Check with your group leader for details.

Section 2 – Dental

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

Section 3 – Authorization

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

Please note: If you do not have minimum essential coverage (MEC), you may be subject to the individual mandate penalty under the Affordable Care Act.

Your signature required

Employee Signature

_____/_____/_____
Date Signed

Print Name

Employer Name

Group Number