MASSACHUSETTS

INSURANCE WAIVER FORM

Please complete this form if you're waiving the following insurance coverage that's offered through your employer. Keep a copy for your records, and return the original to your employer.

EMPLOYEE INFORMATION

Company Name	Employee Name	Date of Birth

MEDICAL WAIVER

☐ I waive my employer's group medical insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage (check all that apply):

- ☐ I am covered as a spouse or dependent under another group medical plan.
- ☐ I am covered by Medicare, non-group, Veterans program, or a secondary employer.

  Employer Name: _____ Insurance Company: _____
- ☐ I am not covered by another medical insurance and choose not to participate in my employer's group plan at this time.
- ☐ Other (requires explanation): _____

DENTAL WAIVER

☐ I waive my employer's group dental insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage (check all that apply):

- ☐ I am covered as a spouse or dependent under another group dental plan.
- ☐ I am covered by non-group, Veterans program, or a secondary employer.

  Employer Name: _____ Insurance Company: _____
- ☐ I am not covered by another dental insurance and choose not to participate in my employer's group plan at this time.
- ☐ Other (requires explanation): _____

VISION WAIVER

☐ I waive my employer's group vision insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage (check all that apply):

- ☐ I am covered as a spouse or dependent under another group vision plan.
- ☐ I am covered by Medicare, non-group, Veterans program, or a secondary employer.

  Employer Name: _____ Insurance Company: _____
- ☐ I am not covered by another vision insurance and choose not to participate in my employer's group plan at this time.
- ☐ Other (requires explanation): _____

I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future, under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature	Date

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Blue Cross Blue Shield of Massachusetts has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature	Date

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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