

P.O. Box 91059
Seattle, WA 98111-9159



WAIVER OF COVERAGE

This is to confirm that I decline to participate in the Premera Blue Cross program offered through my employer's group health plan as follows:

- I do not wish to enroll **myself**. I have other Group coverage.
- I do not wish to enroll **myself**. I have other Individual coverage.
- I do not wish to enroll **myself**. I do not have other health care coverage.
- I do not wish to enroll my **spouse** **children**.^{*} They have other Group coverage.
- I do not wish to enroll my **spouse** **children**.^{*} They have other Individual coverage.
- I do not wish to enroll my **spouse** **children**.^{*} They do not have other health care coverage.

* Please list the names of specific children you wish to waive if you are not enrolling all of them:

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have **involuntarily** lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption.

Employee Name _____ Employee Signature _____

Group Name _____ Group Number _____

Employer _____ Date _____ / _____ / _____

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