Blue Cross Blue Shield of Rhode Island

Blue Cross & Blue Shield of Rhode Island
Small Employer Waiver Form/Certification

EMPLOYER NAME		**BCBSRI GROUP NUMBER**
EMPLOYEE NAME		**DATE**
REASON FOR WAIVER *CHECK THE ONE THAT APPLIES*	o Covered under a spouse's plan o Covered under a parent or guardian's plan o Other (PLEASE SPECIFY) _____	**OTHER INSURANCE INFORMATION** o Spouse's BCBSRI Plan o United Healthcare o Neighborhood Health Plan o Tufts Health Plan o None o Other _____
TYPE OF WAIVER *CHECK ALL THAT APPLY*	Waiver is for: o Employee o Spouse o Child/Children	Waiver is for: o Health Only o Dental Only o Health & Dental
LIST THE NAME(S) OF EMPLOYEE'S SPOUSE, AND/OR CHILDREN INCLUDED IN THIS WAIVER	Spouse's Name: _____ Children's Name(s)*: 1. _____ 2. _____ 3. _____ 4. _____ *Note: For children, please list the name of each child who is included in this waiver and is (a) under age 26 or (b) disabled and financially dependent upon the employee.	

I understand that, by waiving coverage under my employer's plan at this time, my request for coverage at a later time may subject me or my dependents to penalties not imposed on other subscribers.

However, if I am declining enrollment for myself or for my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents in my employer's plan if that coverage ends in the future, provided that I request enrollment within thirty (30) days after that coverage ends. In addition, if I get married or have a child (whether by birth, adoption, or placement for adoption) after I decline enrollment, I may be able to enroll myself and my dependents in my employer's plan at that time provided that I request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Complete only one of the following sections (Waiver by Employee or Certification of Employer):

WAIVER BY EMPLOYEE		**CERTIFICATION OF EMPLOYER** The employee was offered coverage and was presented with this form, but he or she declined coverage, refused to sign this form, or was unable to sign it.	
_____ Signature	__/___/___ Date	_____ Signature	__/___/___ Date
Print Name		Print Name	