



Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, Utah 84130-0270

Waiver Form (Group Size 51+)

SECTION 1 - GROUP INFORMATION

Group's Name	Group Number (for existing groups only)

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle)	Social Security Number	Date of Birth
Date of Hire	Average number of hours worked per week	Waiving coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Dependent(s) <input type="checkbox"/> Dependent(s) Only

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Utah (Regence), but I am waiving coverage for the following reason(s). **Check all that apply:**

- I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.
- I currently have medical coverage elsewhere:

Carrier _____

Policy Number _____

Policy Type: Group Individual Medicare TriCare Other _____

- I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time.
- I currently have dental coverage elsewhere:

Carrier _____

Policy Number _____

Policy Type: Group Individual Medicare TriCare Other _____

If you have checked the above for coverage elsewhere, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits).

SECTION 4 - HEALTH INFORMATION

	Yes	No
1) Have you or any family member ever consulted a health care professional for or received counseling or treatment for conditions, disorders, diseases, or problems of or affecting the:		
a) Heart, including a diagnosis or treatment for heart murmur, heart attack, bypass, blood clot, stroke, or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) Immune system, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Liver, including cirrhosis or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
d) Nervous system, including multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's, Parkinson's, Alzheimer's, or dementia?	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you or any family member ever had, been told you had:		
a) Cancer, including skin cancer, Leukemia or tumors?	<input type="checkbox"/>	<input type="checkbox"/>
b) Congenital disorders, including birth defect, development or learning disability, mental impairment, Down syndrome, or autism?	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes, Type I or II?	<input type="checkbox"/>	<input type="checkbox"/>
d) Stroke?	<input type="checkbox"/>	<input type="checkbox"/>



SECTION 4 - HEALTH INFORMATION (continued)

	Yes	No
3) Within the last ten years have you or any family member ever been told you had, consulted a health care professional for, or received counseling or treatment for conditions, disorders, diseases, or problems of or affecting the: a) Ulcerative colitis? b) Alcohol use/abuse, advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for their own alcohol consumption?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4) Within the last five years have you or any family member ever been told you had, consulted a health care professional for, or received counseling or treatment for conditions, disorders, diseases, or problems of or affecting the: a) Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas? b) Muscular system? c) Lungs, including RSV, reactive airway disease, or other respiratory system disorders? d) Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication? e) Sexually transmitted diseases? f) Lupus?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5) Are you or any family member currently taking medications which exceed the cost of \$500 per month? If yes, list medications below.	<input type="checkbox"/>	<input type="checkbox"/>
6) Are you or any family member currently pregnant? If yes, provide due date below.	<input type="checkbox"/>	<input type="checkbox"/>
Explain/List any Yes responses from 1 - 6: _____ _____ _____ _____		

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage (or an employer stops contributing towards other group coverage), provided that you request enrollment within 30 days after you or your dependent's other coverage ends (or employer contributions stop). In addition, if you waive enrollment under this medical/dental plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I have provided these answers as part of the application process required by the Issuer to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence will rely on each answer in making coverage and rating determinations. For protection of all members, knowingly providing false, incomplete, or misleading information for the purposes of defrauding Regence may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

If you are using this form to terminate your existing Regence group coverage, your signature confirms that you do not (or did not) have an expectation of coverage and that you paid no premium(s) after the requested cancellation date.

Signature of Employee

Date

