



# Regence

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

Regence BlueCross BlueShield of Utah

## Waiver Form

### SECTION 1 - GROUP INFORMATION

Group Name	Group Number
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### SECTION 2 - EMPLOYEE INFORMATION

Employee Name (Last, First, Middle)
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Employee Date of Hire	Employee average number of hours worked per week	Waiving coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Dependents <input type="checkbox"/> Dependents Only
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### SECTION 3 - WAIVING COVERAGE INFORMATION

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

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

Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy Type:  Group  Medicare  TriCare  Other \_\_\_\_\_

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

Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

**SECTION 4 - HEALTH INFORMATION**

	YES	NO
1) Have you or any family member <b>ever</b> 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 <b>ever</b> 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"/>
3) Within the last <b>ten years</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>
b) Lupus?	<input type="checkbox"/>	<input type="checkbox"/>
c) 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"/>
4) Within the last <b>five years</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>
b) Muscular system?	<input type="checkbox"/>	<input type="checkbox"/>
c) Lungs, including RSV, reactive airway disease, or other respiratory system disorders?	<input type="checkbox"/>	<input type="checkbox"/>
d) Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication?	<input type="checkbox"/>	<input type="checkbox"/>
e) Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you or any family member currently taking medications which exceed the cost of \$500 per month? <b>If yes, list medications below .</b>	<input type="checkbox"/>	<input type="checkbox"/>
6) Within the last <b>five years</b> have you or any family member ever incurred medical expenses of \$5000 or more in any twelve-month period, or are such medical costs anticipated now or in the future?	<input type="checkbox"/>	<input type="checkbox"/>
7) Are you or any family member currently pregnant? <b>If yes, provide due date and explain below any prior problems with pregnancy.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Explain/List any YES responses from 1 - 7 above:</b>		
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If you are waiving coverage under this medical/dental plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents under this plan if you or your dependents lose eligibility for that other coverage (or an employer stops contributing towards that other coverage), provided that you request enrollment within 30 days after your or your dependents' 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 dependents 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 dependents will be unable to obtain coverage under my group's plan through Regence BlueCross BlueShield of Utah until the next annual enrollment period, unless I and/or my dependents qualify for a special enrollment period.

I have provided these answers as part of the application procedure 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 BlueCross BlueShield of Utah 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 BlueCross BlueShield of Utah may result in Regence BlueCross BlueShield of Utah 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 BlueCross BlueShield of Utah in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

\_\_\_\_\_  
**Signature of Employee** \_\_\_\_\_  
**Date**