Blue Cross Blue Shield Blue Care Network of Michigan

EMPLOYEE WAIVER FORM

Company name: _____
(Please print)

Employee Name: _____
(Please print)

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box below and provide all applicable information.

If your employer offers multiple choices of health insurance plans, please complete the following section:

☐ I am waiving BCN coverage from my employer because I am currently enrolled in BCBSM.

BCBSM Group Number _____

☐ I am waiving BCBSM coverage from my employer because I am currently enrolled in BCN.

BCN Group Number _____

☐ I have coverage other than BCBSM or BCN, offered by my employer.

Carrier Name: _____ Policy/Contract Number: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

If you are waiving coverage offered by your employer for another reason, please complete the following section:

☐ I have my own individual coverage that my employer does not provide any contribution or reimbursement of premiums.

Carrier Name:_____ Policy/Contract Number: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

☐ I am covered under another group health plan, vision plan or dental plan not offered by this employer (through spouse, self, parent, etc):

Carrier Name: _____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

☐ Carrier Coverage indicated is through Marketplace Exchange.

☐ I was not offered health care coverage, vision coverage or dental coverage by this employer.

☐ I do not want coverage offered through this employer (Reason must be provided):_____

_____

The information provided above is true and accurate to the best of my knowledge.

_____ _____
Employee Date of Hire Employee Job Title

_____ _____
Employee signature Date

_____ _____
Employer signature Date