MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts Waiver

Company Name: _____

Employee's Name: _____

Date of Birth: _____

Medical

☐ I waive my employer's group **Medical** insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

☐ I am covered as a spouse or dependant under another group **Medical** plan.

☐ I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer Name: _____

Insurance Company: _____

☐ I am not covered by another **Medical** insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation): _____

Dental

☐ I waive my employer's group **Dental** insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

☐ I am covered as a spouse or dependant under another group **Dental** plan.

☐ I am covered by non-group, Veterans program or a secondary employer.

Employer Name: _____

Insurance Company: _____

☐ I am not covered by another **Dental** insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation):_____

I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature: _____ Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Blue Cross Blue Shield of Massachusetts has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____ Date: _____

Nondiscrimination Notice & Translation Resources

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).