WAIVER OF ENROLLMENT (for group use only)

BlueCross BlueShield of Kansas

BlueCross BlueShield Kansas Solutions

The group insurance program has been offered to me, and I am waiving my right to participate because:

HEALTH/RX

☐ I am covered by my spouse or parent's insurance program which includes:

☐ Health/RX Only ☐ Dental Only ☐ Health/RX and Dental

Spouse or Parent's Name: _____ Plan ID #: _____

Place of Employment: _____

Name of Insurance Company: _____

☐ I do not desire to enroll in Blue Cross and Blue Shield of Kansas coverage at this time and have no other insurance.

☐ Other (Please specify): _____

Notice of Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan following a triggering event. Check with your group leader for details.

DENTAL

☐ I do not desire to enroll in Blue Cross and Blue Shield of Kansas Dental at this time, and have no other Dental Insurance.

Restrictions may apply if you do not enroll at your first opportunity.

Groups must meet Participation Requirements to renew their group sponsored health insurance plan. For more detailed information, please refer to the Eligibility Section of the Group Administration Manual.

Please note; if you do not have minimum essential coverage (MEC), you may be subject to the individual mandate penalty under the Affordable Care Act.

Employee Signature: _____ Employee Name (please print): _____

Employer Name: _____ Group #: _____ Date: _____