MBWWA Group Insurance Plan

WAIVER Form I wish to Decline: ☐ MEDICAL ☐ DENTAL ☐ VISION Coverage

Company Name	Division/ Department No.	Effective Date of Waiver

EFF. DATE	MEDICAL	DENTAL	VISION	Section	Pkg. Code	Billing	BCBSM	FOR INSURANCE USE ONLY

Employee Social Security No. ___/___/___ Employee Last Name _____ Employee Legal First Name _____ M.I. ____

Status: Single ☐ Married ☐ Divorced ☐ Gender: M ☐ F ☐ Date of Birth ___/___/___ Date of Marriage ___/___/___

Home Street Address _____ City _____ State ____ Zip _____

Waiver of Coverage I have been given an opportunity to participate in my Employer's Group Insurance Plan. I agree to voluntarily waive BENEFITS to which I am entitled under my Employer's Group Insurance Plan, I have minimum essential affordable health insurance through my spouse's employer or other alternative coverage. I understand that while coverage is waived, I will not be required to make payroll contributions for declined benefits. I understand that I may resume such coverage if I later lose coverage under the other health coverage provider, provided that I notify my employer within 31 days of loss of other coverage and provide proof of loss of that coverage. ☐ Your family status must be the **same** for medical, vision and dental. For example, if you choose family coverage for medical you may not elect single coverage for dental and or vision. Employee coverage is required for dependents to be eligible for benefits, dependent only coverage is not available. ***List Name, Date of Birth and Social Security Number (if available) of your dependents waiving coverage***

I choose to decline Benefits for:
Myself ☐ _____
My spouse ☐ _____
My dependents ☐ _____
_____
_____
Use the back to list additional dependents _____

My Other Medical Coverage is: ☐ **Individual or Marketplace** ☐ Medicare ☐ TRICARE ☐ Medicaid ☐ Employer-sponsored Group Plan (or COBRA) (as spouse or dependent)
(Provide copy of alternative insurance card)

Note: If you waive coverage considered affordable and minimum essential under the patient Protection and Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual heath insurance on the Marketplace. If you waive coverage and do not obtain coverage on your own (including coverage for all tax expected dependents), you will be subject to a penalty under the individual responsibility requirement of ACA. By signing below, I certify that I have been given the opportunity by my employer to apply for affordable minimum essential coverage, as defined under ACA for myself and my eligible dependents, if any. I am declining enrollment as indicated above and attest that I have read the above and understand the consequences of my waiver of coverage.

_____
Signature of Employee *Date*

As a representative of the Employer, I received this Waiver of Coverage from the above employee on _____.
Date

Please read and sign the reverse of this form

_____
Signature of Employer Representative

TO BE COMPLETED BY THE EMPLOYER

Check all that apply:				Date of Hire: _____	Employee Job Title: _____
	☐ Non Union	☐ New	☐ Loss of coverage		
	☐ Union	☐ Rehire	☐ Retiree		
	☐ Full Time	☐ Transfer			
	☐ Part Time	☐ Return from layoff		**Effective Date:** _____	Annual Wages: _____

Important information regarding your Special Enrollment Rights for Medical Coverage

If you are declining enrollment 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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "31 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent (s). Failing to accurately submit this information for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person (s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person (s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "31 days" after the marriage, birth, adoption, or placement for adoption. Effective April 1, 2009 special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a State Children's Health Insurance Program (SCHIP) coverage and you request enrollment within "60 days" after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a SCHIP program with respect to coverage under this plan and you request enrollment within "60 days" after the determination of eligibility for such assistance.

I have read and understand the information provided regarding this waiver of benefits

_____	_____	_____
Date	***Employee's Signature***	***Spouse's Signature***

NEW EMPLOYEES MUST COMPLETE THE ENROLLMENT FORM

****

Use this space to provide additional dependent information
List Name, Date of Birth and Social Security Number (if available) of your dependents waiving coverage

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____