Blue Cross Blue Shield of Michigan

An Independent Licensee of the Blue Cross Blue Shield Association

Employee Waiver Form

Group Name: _____

BCBSM – Group Number/Suffix _____ BCN – Group ID, Class ID, Sub Group ID _____

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

Employee Name: _____
(Please Print)

I am eligible for group health coverage offered by this employer.

- ❑ I am waiving BCN coverage because I am currently enrolled in BCBSM.
- ❑ I am waiving BCBSM coverage because I am currently enrolled in BCN.
- ❑ I am currently enrolled in a group health program offered by this employer (other than BCBSM or BCN). The information for this coverage is as follows:

_____ Carrier Name _____ Policy/Contract Number

Product Type: ❑ HMO ❑ POS ❑ PPO ❑ Traditional

I hereby waive BCBSM and BCN coverage offered by this employer for the following reason:

- ❑ I have my own individual coverage. The information for this coverage is as follows:

_____ Carrier Name _____ Policy/Contract Number

  - ❑ Please check this box if this employer provides any contribution or reimbursement for this coverage.

- ❑ I am covered under another group health plan not offered by this employer (spouse, self, parent, etc.). The information for this coverage is as follows:

_____ Carrier Name _____ Policy/Contract Number

_____ Policyholder Name _____ Relationship to Employee

- ❑ I was not offered health care coverage by this employer.
- ❑ I do not want the group health care coverage offered through this employer.

  Explain reason: _____

_____

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

_____ Employee Signature _____ Date