

# Waiver of Enrollment

for group use only



## Section 1 – Health/Rx

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

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 Name

\_\_\_\_\_  
Plan ID Number

\_\_\_\_\_  
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.

## Section 2 – Dental

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

## Section 3 – Authorization

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

**Your signature required**

\_\_\_\_\_  
Employee Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Group Number