Blue Cross Blue Shield Blue Care Network of Michigan

EMPLOYEE WAIVER FORM

Company name: _____
(Please print)

Employee Name: _____
(Please print)

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

If your employer offers multiple choices of health insurance plans, please complete the following section:

☐ I am waiving BCN coverage from my employer because I am currently enrolled in BCBSM.

BCBSM Group Number _____

☐ I am waiving BCBSM coverage from my employer because I am currently enrolled in BCN.

BCN Group Number _____

☐ I have coverage other than BCBSM or BCN, offered by my employer.

Carrier Name: _____

Policy/Contract Number: _____

If you are waiving coverage offered by your employer for another reason, please complete the following section:

☐ I have my own individual coverage:

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, vision plan or dental plan not offered by this employer (through spouse, self, parent, etc):

Carrier Name: _____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

☐ I was not offered health care coverage, vision coverage or dental coverage by this employer.

☐ I do not want coverage offered through this employer (Reason must be provided):_____

_____

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

_____	_____	_____
Employee signature	Job Title	Date
_____	_____	_____
Employer signature	Job Title	Date

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