Blue Cross Blue Shield of Rhode Island

Reason for Waiver of Coverage

Employer Name: _____

Employee Name: _____

Benefit Waiver: ☐ Health Coverage ☐ Dental Coverage

I have declined coverage through my employer's group health plan for the following reason:

- ☐ I am covered by my employer with another insurance company.
- ☐ I am covered as a dependent (spouse/child) under another group plan.
- ☐ Other, please explain _____

Name of Carrier providing coverage: _____

Signature of Employee: _____ Date _____

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