Blue Cross & Blue Shield of Rhode Island
Small Employer Waiver Form/Certification

Employer Name		**Group Id. No.**
Employee Name		**Date**

Reason for Waiver **Check the one that applies**	❏ Covered under a spouse's plan ❏ Covered under a parent or guardian's plan ❏ Other (please Specify):__________________ ______________________________________ ______________________________________	**OTHER INSURANCE INFORMATION** Name of policy holder with other insurance: ______________________________________ Name of other insurance: ______________________________________ ______________________________________
Type of Waiver **Check all that apply**	Waiver is for: ❏ Employee ❏ Spouse ❏ Child/Children	Waiver is for: ❏ Health only ❏ Dental only ❏ Health & Dental
List the Names of Employee's Spouse, and/or children included in this waiver	Spouse's Name: ______________________________ Children's Names*: 1. ______________________________ 2. ______________________________ 3. ______________________________ 4. ______________________________ *Note: For children, please list the name of each unmarried child who is included in this waiver and is (a) under age 19; (b) a student between the ages of 19 and 25 that is financially dependent upon the employee; or (c) disabled and financially dependent upon the employee.	

I understand that, by waiving coverage under my employer's plan at this time, my request for coverage at a later time may subject me or my dependents to penalties not imposed on other subscribers, including, if applicable, the application of a pre-existing condition exclusion provision.

However, if I am declining enrollment for myself or for my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents in my employer's plan without any pre-existing condition exclusion if that coverage ends in the future, provided that I request enrollment within thirty (30) days after that coverage ends. In addition, if I get married or have a child (whether by birth, adoption, or placement for adoption) after I decline enrollment, I may be able to enroll myself and my dependents in my employer's plan at that time without any pre-existing condition exclusion, provided that I request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Complete only one of the following sections (Waiver by Employee or Certification of Employer):

Waiver by Employee		**Certification of Employer** The employee was offered coverage and was presented this form, but he or she declined coverage, refused to sign this form, or was unable to sign it.	
______________________ SIGNATURE	____/____/____ DATE	______________________ SIGNATURE	____/____/____ DATE

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