

Blue Cross & Blue Shield of Rhode Island
Small Employee Waiver Form/Certification
 Please complete all fields.

EMPLOYER NAME		BCBSRI GROUP NUMBER	
EMPLOYEE NAME		DATE	
REASON FOR WAIVER CHECK THE ONE THAT APPLIES	☐ Covered by Medicare ☐ Covered under a spouse's plan ☐ Covered under a parent or guardian's plan ☐ Covered under another plan offered by the employer listed above ☐ Other (PLEASE SPECIFY) 		
TYPE OF WAIVER CHECK ALL THAT APPLY	Waiver is for: ☐ Employee ☐ Spouse ☐ Child/Children	Waiver is for: ☐ Health Only ☐ Dental Only ☐ Health & Dental	
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. 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 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 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 with this form, but he/she declined coverage, refused to sign this form, or was unable to sign it.	
Signature	Date	Signature	Date
Print Name		Print Name	