

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

EMPLOYER NAME		GROUP ID. NO.
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EMPLOYEE NAME		DATE
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REASON FOR WAIVER <i>CHECK THE ONE THAT APPLIES</i>	<input type="checkbox"/> COVERED UNDER A SPOUSE'S PLAN <input type="checkbox"/> COVERED UNDER A PARENT OR GUARDIAN'S PLAN <input type="checkbox"/> OTHER (PLEASE SPECIFY): _____ _____ _____	OTHER INSURANCE INFORMATION Name of policy holder with other insurance: _____ Name of other insurance: _____ _____
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TYPE OF WAIVER <i>CHECK ALL THAT APPLY</i>	Waiver is for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child/Children	Waiver is for: <input type="checkbox"/> Health only <input type="checkbox"/> Dental only <input type="checkbox"/> Health & Dental
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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 child who is included in this waiver and is (a) under age 26 or (b) disabled and financially dependent upon the employee.
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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
_____ PRINT NAME		_____ PRINT NAME	