# Employee Waiver Form

## EmployeeElect, EmployeeChoice, and BeneFits Waiver for CA Small Groups

Health care plans offered by Anthem Blue Cross
Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company

**INSTRUCTIONS:**
Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Note: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.


Anthem BlueCross

**Anthem Blue Cross Small Group Services**
PO Box 9062
Oxnard, CA 93031-9062

**anthem.com/ca**


Group no.

### SECTION 1: EMPLOYEE INFORMATION

| Last name | First name | M.I. | Social Security no. (required) |
|---|---|---|---|
| | | | |

| Street address (PO box not acceptable unless rural PO box) | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Email address | Employment status (required) ☐ Part-time ☐ Full-time |
|---|---|
| | |

| Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP) | No. of dependents including spouse/DPs | Spouse/DP's Social Security no. | Home phone no. |
|---|---|---|---|
| | | | |

| Employer name | Hire date (required) | Occupation/job title (required) | Business phone no. |
|---|---|---|---|
| | | | |

Language choice (optional)
☐ English (ENG) ☐ Spanish (SPA) ☐ Korean (KOR) ☐ Chinese (ZHOXC/M) ☐ Vietnamese (VIE) ☐ Tagalog (TGL) ☐ Other (W09) _____

### SECTION 2: LIFE INSURANCE BENEFICIARY

| Last name | First name | Social Security no. | Relationship |
|---|---|---|---|
| | | | |

### SECTION 3: COVERAGE DECLINED OR REFUSED – Complete only if any coverage is declined or refused by you and/or your eligible dependents

| Type of coverage | Waived for | Reason for declining or refusing coverage – Proof of coverage will be required) |
|---|---|---|
| ☐ Medical coverage | ☐ Self ☐ Spouse/DP ☐ Child(ren) | ☐ Covered by other employer – sponsored group plan Carrier name: _____ ID No. _____ ☐ Covered by individual policy Carrier name: _____ ID No. _____ ☐ Covered by: Tricare ☐ Medicare ☐ MediCal ☐ Enrolled in any other insurance plan Carrier name: _____ ID No. _____ ☐ List names of dependents to be waived _____ ☐ Other _____ |
| ☐ Dental coverage (if offered) | ☐ Self ☐ Spouse/DP ☐ Child(ren) | |
| ☐ Vision coverage (if offered) | ☐ Self ☐ Spouse/DP ☐ Child(ren) | |
| ☐ Life coverage (if offered) | ☐ Self ☐ Spouse/DP ☐ Child(ren) | |

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer health benefit plan, a state child health insurance program, or a state Medicaid plan was the reason for waiving enrollment and I lose coverage under that employer health benefit plan, a state child health insurance program, or a state Medicaid plan; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I waived enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If I waived enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment for this group coverage within 60 days: (a) after the date my coverage under any of these plans ends; or (b) after the date I become eligible for state premium assistance for group coverage.

**Please examine your options carefully before waiving this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.**

| Signature if declining or refusing coverage for yourself or dependents | Date |
|---|---|
| **X** | |