



An Independent Licensee of the Blue Cross and Blue Shield Association

120 Fifth Avenue
Pittsburgh PA 15222-3099

WAIVER OF INSURANCE COVERAGE

A. APPLICANT INFORMATION (Please Print):

Employee Name: _____

Date of Birth: _____ SS #: _____

Employer Name: _____ Hire Date: _____

B. OTHER INSURANCE INFORMATION:

I elect to waive health care coverage offered by my employer through Highmark Blue Cross Blue Shield. I currently:

- Do not have health coverage under any health plan.
- Do have health coverage through (please complete the following information):

| | |
|--|----------------------|
| CONTRACT HOLDER NAME | |
| NAME OF HEALTH CARE PLAN/INSURER | |
| GROUP NUMBER | SUBSCRIBER ID NUMBER |
| RELATIONSHIP OF CONTRACT HOLDER TO YOU | |

► I decline coverage for the following individuals. Please check (✓) types of coverage being waived for each individual.

| | | | | COVERAGE WAIVED | | |
|-----------|-----------|------------|----|-----------------|------|--------|
| | LAST NAME | FIRST NAME | MI | MEDICAL | DRUG | VISION |
| EMPLOYEE | | | | | | |
| SPOUSE | | | | | | |
| DEPENDENT | | | | | | |
| DEPENDENT | | | | | | |
| DEPENDENT | | | | | | |
| DEPENDENT | | | | | | |

C. VALIDATION/AUTHORIZATION STATEMENT:

► I hereby certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer through Highmark Blue Cross Blue Shield and/or Subsidiaries. I understand that in the event that I decide to apply for this coverage at a later date, not related to a lifestyle change, I and/or any other eligible dependents **may be** subject to certain waiting periods involving any pre-existing conditions.

Employee Signature _____ Date _____