BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association.

Waiver of Group Health Insurance Benefits

Employer's Name (Please Print)

Employee's Name (Please Print)

PLEASE CHOOSE THE APPLICABLE OPTION BELOW.

I choose to decline enrolling myself and/or my eligible dependent(s) in the group insurance plan(s) indicated below. *

**Please indicate your waiver of coverage by checking all applicable categories and selected family members.*

- ☐ *Group Medical Plan*
- ☐ *Exclude Myself*
- ☐ *Exclude My Spouse*
- ☐ *Exclude My Child(ren)*

Reasons for declining coverage:

- ☐ *Covered by Spouse's plan*
- ☐ *Covered by other insurance*
- ☐ *Covered by HMO*
- ☐ *Other (Explain)*

I acknowledge that my employer has explained the coverage(s) available.

I have been given the opportunity to enroll in my employer's group medical plan for the coverage(s) and have elected not to enroll myself and/or my dependents, if any.

I understand that I will not be able to enroll in the plan until the next open enrollment period.

Electronic Employee Signature_____ Date_____

ONLY COMPLETE AND SIGN THIS FORM IF COVERAGE IS BEING WAIVED