Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103

Independence Blue Cross

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

CUSTOMER NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYEE NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ ☐

Last First M.I.

SOCIAL SECURITY # ☐☐☐ ☐☐ ☐☐☐☐

DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ **DATE OF HIRE** ☐☐ ☐☐ ☐☐☐☐

Month Day Year Month Day Year

MARITAL STATUS ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Independence Blue Cross through its subsidiaries Keystone Health Plan East and QCC Insurance Company and Highmark Blue Shield.

REASON FOR REFUSAL (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer *
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other-reasons--please explain

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* Must meet participation guidelines, if applicable.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form, and coverage may be subject to a pre-existing conditions exclusions.

Signature of Employee ____________________ Date ____________________

Signature of Witness ____________________ Date ____________________