Capital BlueCross

Capital BlueCross and its subsidiary,
Capital Advantage Insurance Company® (collectively "Capital")
Independent Licensees of the Blue Cross and Blue Shield Association

Harrisburg, PA 17177
1-866-686-2242
www.capbluecross.com

WAIVER OF GROUP HEALTH INSURANCE COVERAGE

ALL SHADED AREAS MUST BE COMPLETED

1. APPLICANT INFORMATION

APPLICANT'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.
SPOUSE'S NAME	(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NO.

2. VALIDATION STATEMENT

I hereby certify that I have been given the opportunity to participate in the group health insurance plan provided by my employer through Capital. This plan has been explained to me and I decline to participate in:

☐ EMPLOYEE COVERAGE ☐ SPOUSE COVERAGE ☐ OTHER ELIGIBLE DEPENDENT COVERAGE

3. OTHER INSURANCE INFORMATION

Complete the following information for applicant and/or spouse and/or other eligible dependent(s) waiving coverage because they are currently covered for health care services with a Blue Cross and/or Blue Shield Plan, an insurance company, an HMO, or other health care plan.

NAME OF CONTRACTHOLDER	NAME AND LOCATION (STATE) OF HEALTH CARE PLAN / INSURANCE CO.	POLICY / IDENTIFICATION NO.

4. WAIVER INFORMATION

NAME (LAST) (FIRST) (MI)	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NO.
a. APPLICANT →		
b. SPOUSE →		
c. ELIGIBLE DEPENDENT		
d. ELIGIBLE DEPENDENT		
e. ELIGIBLE DEPENDENT		
f. ELIGIBLE DEPENDENT		

5. COVERAGE BEING WAIVED (CHECK (✓) COVERAGE BEING WAIVED)

Hospital	Med-Surg	Major Medical	Comp	PPO	POS	Dental	Vision	Rx Drug	Senior-Part A	Senior-Part B

6. STATEMENT AUTHORIZATION

I understand that in the event that I decide to apply for this coverage at a later date, I and/or my spouse and/or any other eligible dependents, may be subject to certain waiting periods involving any preexisting conditions.

EMPLOYEE SIGNATURE	DATE
NAME OF GROUP	GROUP NO.

ORIGINAL — Capital 1st COPY — Applicant Copy 2nd COPY — Group Copy

C-69 (11/2002)

SEE REVERSE FOR INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING WAIVER

The information below shows the sections of the form that must be completed and describes the type of information needed to process your Waiver of Coverage. A waiver form must be completed when the applicant and/or spouse and/or any eligible dependent does not enroll for health insurance products offered by the employer.

1. APPLICANT INFORMATION

Print clearly your name, your Social Security Number, and if applicable, your spouse's name and your spouse's Social Security Number.

2. VALIDATION STATEMENT

Check "Employee Coverage" if coverage is being waived by the employee on behalf of self for one or more types of coverages. Check "Spouse Coverage" if coverage is being waived on behalf of the spouse. Check "Other Eligible Dependent Coverage" if coverage is being waived on behalf of other eligible dependent(s).

3. OTHER INSURANCE INFORMATION

Complete this section if you and/or your spouse and/or any of your dependents are waiving coverage because you/they are currently covered for health care services with a Blue Cross and/or Blue Shield Plan, an insurance company, an HMO, or other health care plan. Print the name of the person holding the contract, the name of the Blue Cross and/or Blue Shield Plan, the insurance company, HMO or other health care plan, and the policy or Identification Number of the contract. If you and/or any of your dependents are waiving coverage and electing to have no health care coverage, write "No Coverage" under the "Name of Health Care Plan/Insurance Co." column.

4. WAIVER INFORMATION

Print the name, relationship, and Social Security Number of each eligible dependent waiving health care coverage under your group's contract.

5. COVERAGE BEING WAIVED

Check the type(s) of coverage being waived for each individual in section four.

This section may need to be completed with the assistance of the Group Leader and should be reviewed by the Group Leader.

6. STATEMENT AUTHORIZATION

Sign and date the Waiver of Group Health Insurance Coverage form (C-69).

Write the name of the group customer that is used for billing and contracting purposes.

This section should be completed by the Group Leader or with his or her assistance.