

# Employee Waiver Form

## Employee Elect, Employee Choice, 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

Anthem Blue Cross Small Group Services  
P.O. Box 9062  
Oxnard, CA 93031-9062

**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.

[anthem.com/ca](http://anthem.com/ca)

Group no.
-----------

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

**SECTION 1: EMPLOYEE INFORMATION**

Last name		First name		M.I.	Social Security No.	
Home address (must be complete)			City		State	ZIP code
Mailing address (if different than above) or P.O. Box Private Mail Box (PMB) no.			City		State	ZIP code
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (DP)	No. of dependents including spouse/DPs		Spouse/DP's Social Security No.		Home phone no.
Employer name		Hire date (MM/DD/YYYY)		Occupation/job title		Business phone no.
Language choice (optional)						
<input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Chinese (ZHXC/M) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL) <input type="checkbox"/> Other (W09) _____						

**SECTION 2: ELECTION NOT TO ENROLL – Please complete if you want to waive coverage for yourself and/or any eligible dependents**

Type of coverage	Waived for	Reason for waiving coverage: (Proof of coverage will be required)
<input type="checkbox"/> Medical coverage	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by spouse's/domestic partner's sponsored group plan Carrier name: _____ ID No. _____
<input type="checkbox"/> Dental coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by individual policy Carrier name: _____ ID No. _____
<input type="checkbox"/> Vision coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> MediCal <input type="checkbox"/> Enrolled in any other insurance plan Carrier name: _____ ID No. _____
<input type="checkbox"/> Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> List names of dependents to be waived _____ <input type="checkbox"/> Other _____

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 waiving coverage for self/dependents	Date (MM/DD/YYYY)
---	-------------------