Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
200 SW Market Street
Portland, Oregon 97201
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax to: 1-866-303-5117

Waiver Form

SECTION 1 - GROUP INFORMATION

Group's Name	Group Number (for existing groups only)
Golden Cabinet, LLC	1 0 0 4 9 1 9 3

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle)	Date of Birth

Date of Hire	Average number of hours worked per week	Waiving coverage for: ☐ Employee ☐ Employee/Dependent(s)

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Oregon (Regence), but I am waiving coverage for the following reason(s). **Check all that apply:**

☐ I do not wish to enroll myself and/or my dependent(s) in my group's **medical** plan at this time.

☐ I currently have medical coverage elsewhere:

Carrier_____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ Medicaid ☐ TriCare ☐ Indian Health Service ☐ Government sponsored health plan ☐ Other_____

☐ I do not wish to enroll myself and/or my dependent(s) in my group's **dental** plan at this time.

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage or an employer stops contributing towards that other coverage provided that you request enrollment within 30 days after your other coverage ends. In addition, if you waive enrollment under this medical plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I further certify that all information completed on this form is true, correct and complete and acknowledge that my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

▶ _____ _____

Signature of Employee | Date

F4517.XOR0EN09230101