



**Blue Cross
Blue Shield**
of Michigan

An Independent Licensee of
the Blue Cross Blue Shield
Association

<h1>Employee Waiver Form</h1>

Group Name: _____

BCBSM – Group Number/Suffix _____ BCN – Group ID, Class ID, Sub Group ID _____

Please check the appropriate box below and provide all applicable information:

Employee Name: _____
(Please Print)

I am eligible for group health coverage offered by this employer.

- I am waiving BCN coverage because I am currently enrolled in BCBSM.
- I am waiving BCBSM coverage because I am currently enrolled in BCN.
- I am currently enrolled in a group health program offered by this employer (other than BCBSM or BCN). The information for this coverage is as follows:

Carrier Name	Policy/Contract Number
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Product Type: HMO POS PPO Traditional

I hereby waive BCBSM and BCN coverage offered by this employer for the following reason:

- I have my own individual coverage. The information for this coverage is as follows:

Carrier Name	Policy/Contract Number
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- Please check this box if this employer provides any contribution or reimbursement for this coverage.

- I am covered under another group health plan not offered by this employer (spouse, self, parent, etc.). The information for this coverage is as follows:

Carrier Name	Policy/Contract Number
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Policyholder Name	Relationship to Employee
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- I was not offered health care coverage by this employer.
- I do not want the group health care coverage offered through this employer.

Explain reason: _____

The information printed above is true and accurate to the best of my knowledge.

Employee Signature

Date