

**Blue Cross & Blue Shield of Rhode Island
Small Employer Waiver Form/Certification**

EMPLOYER NAME		GROUP ID. NO.	
EMPLOYEE NAME		DATE	
NAME OF EMPLOYEE'S SPOUSE AND/OR CHILDREN (IF APPLICABLE)	Note: For children, please list the name of each unmarried child who is (a) under age 19; (b) aged 19 to 25, a full-time student, and financially dependent upon you; or (c) financially dependent upon you because he or she is disabled.	<ul style="list-style-type: none"> • Spouse's Name: • Children's Names: 	

TYPE OF WAIVER	<input type="checkbox"/> Waiver is for Employee	Waiver is for: <input type="checkbox"/> Health only <input type="checkbox"/> Dental only <input type="checkbox"/> Health & Dental
CHECK ALL THAT APPLY	<input type="checkbox"/> Waiver is for Spouse	
	<input type="checkbox"/> Waiver is for Child/Children	

REASON FOR WAIVER	<input type="checkbox"/> COVERED UNDER A SPOUSE'S PLAN (List First Name of Spouse and Children if applicable). Spouse's Coverage:
CHECK THE ONE THAT APPLIES	<input type="checkbox"/> COVERED UNDER A PARENT OR GUARDIAN'S PLAN Parent/Guardian's Coverage:
	<input type="checkbox"/> OTHER (PLEASE SPECIFY):

I understand that, by waiving coverage under my employer's plan at this time, my request for coverage at a later time may subject me or my dependents to penalties not imposed on other subscribers, including, if applicable, the application of a pre-existing condition exclusion provision.

However, if I am declining enrollment for myself or for my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents in my employer's plan without any pre-existing condition exclusion if that coverage ends in the future, provided that I request enrollment within thirty (30) days after that coverage ends. In addition, if I get married or have a child (whether by birth, adoption, or placement for adoption) after I decline enrollment, I may be able to enroll myself and my dependents in my employer's plan at that time without any pre-existing condition exclusion, provided that I request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Complete only one of the following sections (Waiver By Employee or Certification of Employer):

WAIVER BY EMPLOYEE		CERTIFICATION OF EMPLOYER	
		The employee was offered coverage and was presented this form, but he or she declined coverage, refused to sign this form, or was unable to sign it.	
SIGNATURE	DATE	SIGNATURE	DATE
PRINT NAME		PRINT NAME/TITLE	