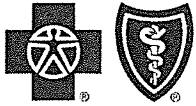

BlueCross BlueShield
of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Vermont
The Vermont Health Plan

Waiver of Group Health Insurance Benefits

Employer's Name: ______________________________

Employee's Name: ______________________________

Social Security Number: *(optional)* ______________________________

I have been given the opportunity to enroll myself and my legal dependents in my employer's group health benefit plan(s). I choose to decline enrolling in the insurance plan(s) offered by Blue Cross and Blue Shield of Vermont and/or The Vermont Health Plan. My reason for declining coverage is indicated below:

Covered by spouse's plan:

Company: __________________ Policy #: __________________

Covered by other employer's plan:
Company: __________________ Policy #: __________________

Covered by other insurance:
Company: __________________ Policy #: __________________

Other (explain):______________________________

I acknowledge that my employer has explained the coverage(s) available. I have been given the opportunity to enroll for coverage and have elected not to enroll as indicated above.

Employee Signature: ______________ Date: __________________

Employer Signature:______________ Date: __________________

To be completed and signed only if coverage is being waived.

06/09