

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

<b>EMPLOYER NAME</b>		<b>GROUP ID. NO.</b>
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<b>EMPLOYEE NAME</b>		<b>DATE</b>
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<b>REASON FOR WAIVER</b>  <i>CHECK THE ONE THAT APPLIES</i>	<input type="checkbox"/> COVERED UNDER A SPOUSE'S PLAN  <input type="checkbox"/> COVERED UNDER A PARENT OR GUARDIAN'S PLAN  <input type="checkbox"/> OTHER (PLEASE SPECIFY): _____ _____ _____	<b>OTHER INSURANCE INFORMATION</b> Name of policy holder with other insurance: _____ Name of other insurance: _____ _____
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<b>TYPE OF WAIVER</b>  <i>CHECK ALL THAT APPLY</i>	Waiver is for: <input type="checkbox"/> Employee  <input type="checkbox"/> Spouse  <input type="checkbox"/> Child/Children	Waiver is for: <input type="checkbox"/> Health only  <input type="checkbox"/> Dental only  <input type="checkbox"/> Health & Dental
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<b>LIST THE NAMES OF EMPLOYEE'S SPOUSE, AND/OR CHILDREN INCLUDED IN THIS WAIVER</b>	Spouse's Name: _____  Children's Names*: 1. _____ 2. _____ 3. _____ 4. _____  *Note: For children, please list the name of each unmarried child who is included in this waiver and is (a) under age 19; (b) a student between the ages of 19 and 25 that is financially dependent upon the employee; or (c) disabled and financially dependent upon the employee.
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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):**

<b>WAIVER BY EMPLOYEE</b>		<b>CERTIFICATION OF EMPLOYER</b>	
		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	