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