HIGHMARK® Delaware

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WAIVER OF GROUP HEALTH AND/OR DENTAL COVERAGE (WOC)

SECTION 1: EMPLOYEE INFORMATION

Name:	Social Security Number:
Address:	Employer:
	Date of Hire:

SECTION 2: PERSONS DECLINING COVERAGE

Please check the appropriate box(es): ☐ Employee ☐ Spouse* ☐ Children

SECTION 3: REASON FOR DECLINING COVERAGE

Please check the appropriate box:

☐ Covered under my spouse's* employer's insurance policy.
Employer's Name: _____

☐ Covered under my other employer.
Employer's Name: _____

☐ Covered under retirement benefits.
Employer's name: _____

☐ Covered under COBRA benefits through my former employer.
Date coverage as an employee (or dependent) terminated: _____

☐ Covered as ***an eligible dependent*** under my parent's health insurance policy.
Parent's name: _____

☐ Covered under my own or spouse's* self-purchased health insurance.
Effective date of coverage: _____

☐ Covered under Medicare.

☐ Covered under Medicaid.

☐ I do not want health insurance.

☐ I do not want dental insurance.

☐ Already covered by dental insurance with (insurer's name): _____
Please check the appropriate box(es): ☐ Employee ☐ Spouse* ☐ Children

☐ Other:

SECTION 4: EMPLOYEE SIGNATURE

I am aware of the availability of health and/or dental coverage through my employer and I am declining coverage for myself and/or any eligible dependents listed for the reason(s) indicated above. I also understand that if I and/or my eligible dependents do not enroll when first eligible, I/ we will be subject to a pre-existing condition waiting period of 12 months from the date of enrollment.

Employee Signature: **Date:**

Employer:
- Keep a copy of this document.
- Mail the original to:
  Highmark Blue Cross Blue Shield Delaware
  Attn.: Underwriting Dept.
  P.O. Box 8868
  Wilmington, DE 19899

**Important Note: As of January 1, 2012, the definition of spouse includes a civil union partner.*

(see other side for information about this form)

WAIVER OF GROUP HEALTH AND/OR DENTAL INSURANCE

INSTRUCTIONS

If you or a member of your family are not enrolling for health and/or dental benefits through your employer's program:

- You must complete Sections 1 through 4 of this form.
- After you sign your name in Section 4, be sure to return it to your employer—who will forward the form on to us.
- If you have any questions, please see your benefits personnel or contact your Highmark Blue Cross Blue Shield Delaware representative.

Important Note: As of January 1, 2012, the definition of spouse includes a civil union partner.

Background

Under Delaware Law, if you decide not to enroll yourself and/or your eligible dependents in your employer's group health benefits program, you may be required to complete and sign this waiver of coverage. Complying signifies that you are aware of the availability of health and/or dental benefits through your employer—and that the preexisting conditions waiting period may be longer if you decide to enroll later.

Your completion of this form also helps us to measure the level of participation in your employer's health (and dental, if offered) benefits program. It also helps to ensure benefits are properly administered with respect to Medicare and other health benefits programs. Please be assured the information you provide will be kept strictly confidential.

If You Wait To Enroll

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future.

You may be eligible to enroll in the future if you request to enroll within 30 days:

- after your coverage ends, or
- of your marriage, or
- of your new dependent's birth or adoption (or placement for adoption)

Under these conditions, you and/or your dependents would be considered a "timely enrollee." As a timely enrollee, the waiting period for coverage of your preexisting conditions would not be extended beyond the period that would otherwise apply.