



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts Waiver

Company Name: The Cove at Yarmouth
Employee's Name: _____
Date of Birth: _____

Medical

☐ I waive my employer's group Medical insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

- ☐ I am covered as a spouse or dependant under another group Medical plan.
☐ I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer Name: _____

Insurance Company: _____

☐ I am not covered by another Medical insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation): _____

Dental (N/A)

☐ I waive my employer's group Dental insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

- ☐ I am covered as a spouse or dependant under another group Dental plan.
☐ I am covered by non-group, Veterans program or a secondary employer.

Employer Name: _____

Insurance Company: _____

☐ I am not covered by another Dental insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation): _____

I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature: X _____

Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Blue Cross Blue Shield of Massachusetts has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____

Date: _____