

REGOVED TO WITH ON

Blue Cross Blue Shield of Massachusetts Waiver

| company Name: The Cove at Yarmouth | |
|--|--|
| Employee's Name: | |
| Date of Birth: | |
| | |
| _/ | Dental (M/A) |
| eligible dependents (if any). | waive my employer's group Dental insurance coverage for payself and my eligible dependents (if any). |
| Reason for Waiver of Coverage - check all that apply: | Reason for Waiver of Coverage - check all that apply: |
| am covered as a spouse or dependant under another group Medical plan. | I am covered as a spouse or dependant under another group Dental plan. |
| am covered by Medicare, non-group, Veterans program or a secondary employer. | _l am covered by non-group, Veterans program or a secondary employer. |
| Employer Name:Employ | Employer Name: |
| Insurance Company:Insuran | Insurance Company: |
| I am not covered by another Medical insurance and choose not to participate J a in my employer's group plan at this time. |] am not covered by another Dental insurance and choose not to participate in my employer's group plan at this time. |
| Other (requires explanation):Other/fr | Other (fequires 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. | understand that I and/or my dependents may enroll under this plan in the future under |
| Employee Signature: 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. | and that Blue Cross Blue Shield of Massachusetts has the right to terminate coverage, ined in this form. |
| Employer Signature:Date: | |

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