CareFirst BlueChoice

CareFirst BlueCross BlueShield

Waiver of Enrollment Form

Employee Name _____ Social Security Number _____

Group Name _____ Group Number _____

Employment date _____

I certify that the health protection plan of CareFirst BlueCross BlueShield/CareFirst BlueChoice has been explained to me and at this time I choose:

❑ Not to enroll or, FOR ❑ myself and my dependents, (if any)

❑ If enrolled, to cancel coverage ❑ my dependents only

The other coverage is (select one):

❑ Commercial Insurance Policy (employer sponsored only)
❑ Spouse's group health benefit plan
❑ CHAMPUS
❑ Medicare as primary under TEFRA
❑ COBRA

Note that coverage through an individual policy is not considered a valid reason for waiver.

Please check which benefits you and/or your dependents have with the other carrier.

❑ Medical
❑ Dental
❑ Vision

I understand that if I decide later to enroll myself and/or dependents, all such late enrollees will be subject to the special enrollment requirements, as detailed on the next page. I declare that the information I have furnished above, to the best of my information and belief, is true, correct and complete.

Signature of Employee_____ Date_____

CUT6529-1S (6/04)

You or your dependent(s) are not considered Late Enrollees when you or your dependent(s) are covered under your spouse's or parent's coverage through another group and:

a) You and/or your dependent(s) are not longer eligible under your spouse's coverage because your spouse's employment or his or her group has been terminated;

b) You are no longer eligible or included under your spouse's coverage due to legal separation or divorce;

c) Your dependent is no longer eligible or included under your spouse's coverage due to legal separation or divorce or the dependent's age;

d) You and/or your dependent(s) are no longer eligible under your spouse's coverage due to the death of your spouse;

e) You are no longer eligible under your parent's coverage;

f) You and/or your dependent(s) have coverage through another group but later become ineligible for coverage through that group (including COBRA participants).

In the above situations, you will not be treated as a Late Enrollee, provided you and/or your eligible dependent(s) enroll within 31 days of the termination date of your prior coverage and submit, as necessary, a letter from your spouse's former employer. This letter must indicate when the spouse's employment terminated, whether the spouse's employment terminated, when the spouse's coverage terminated, whether the spouse was enrolled under individual or family coverage, and a statement indicating that the employer contributed toward the cost of coverage. A similar letter is also required for dependents that are no longer eligible under their parent's coverage. Please contact your Group Administrator if you have any questions about these enrollment requirements.

Please return this form to:

CareFirst BlueCross BlueShield / CareFirst BlueChoice, Inc.
Enrollment & Billing
10455 Mill Run Circle
Owings Mills, MD 21117
Mail Stop 02-330