

BLUE CROSS BLUE SHIELD OF VERMONT
DELTA DENTAL

**WAIVER OF GROUP HEALTH INSURANCE BENEFITS
(FOR BOTH MEDICAL AND/OR DENTAL COVERAGE)**

EMPLOYER'S NAME: _____

EMPLOYEE'S NAME: _____ Social Security #: _____

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 Blue Shield of Vermont and/or Delta Dental.

My reason for declining coverage is indicated below:

Medical: _____

Dental: _____

(Please mark which coverage(s) you are declining)

____ Covered by spouse's plan
Carrier: _____
Policy # _____

____ Covered by spouse's plan
Carrier: _____
Policy # _____

____ Covered by other employer's plan
Carrier: _____
Policy # _____

____ Covered by other employer's plan
Carrier: _____
Policy # _____

____ Covered by other insurance
Carrier: _____
Policy # _____

____ Covered by other insurance
Carrier: _____
Policy # _____

____ Other (explain): _____

____ 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