

# Waiver of Coverage



651 Perimeter Drive, Suite 300, Lexington, KY 40517  
 Phone: 800-787-2680 Fax: 859-335-3721

<b>1</b>	<b>EMPLOYER</b>	
Company Name		Group Number

<b>2</b>	<b>EMPLOYEE INFORMATION</b>		
Full Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Gender (Check One)
			<input type="checkbox"/> M <input type="checkbox"/> F
		Social Security Number	

<b>3</b>	<b>DEPENDENT INFORMATION (if applicable)</b>			
Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Gender (Check One)	Social Security Number
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	

<b>4</b>	<b>OTHER INSURANCE</b>				
I am currently covered under the contract of my					
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent	<input type="checkbox"/> Medicare	<input type="checkbox"/> None
		<input type="checkbox"/> Individual	<input type="checkbox"/> Other _____		
Employer of person with other coverage _____					
Insurance Carrier of person with other coverage _____					

<b>5</b>	<b>AGREEMENT</b>	
<p>If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependents other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage). Once the completed request for enrollment has been received, the coverage effective date will be no later than the first day of the first calendar month following the date of loss.</p> <p>If you are waiving coverage and you currently have no health care insurance you (and any dependents) must wait until your employer's next open enrollment period to enroll.</p> <p>Whether you declined coverage or are a participant in the plan, you may be able to enroll yourself and/or your dependents if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.</p> <p>To request enrollment or obtain more information, contact your benefit administrator at your place of employment.</p> <p>It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. (TN) TCA § 56-53-111, (IN) IC §35-43-5-3.5</p> <p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. KRS § 304.47-030</p>		
<p>I, the undersigned, an employee of the above named employer, hereby acknowledge that I have been given an opportunity to apply for Bluegrass Family Health coverage, as offered by said employer, and have decided to decline the coverage for:</p> <p><input type="checkbox"/> Myself    <input type="checkbox"/> Spouse    <input type="checkbox"/> Dependent Child(ren) (check all that apply)</p>		
Employee Name (please print) _____		Employee Signature _____
		Date _____
Witness Name (please print) _____		Witness Signature _____
		Date _____