BlueCross BlueShield of South Carolina

OPEN ENROLLEMT 2017-2018

EMPLOYEE WAIVER FORM

Company name: **ASSOCIATE REFORMED PRESBYTERIAN CHURCH - GENERAL SYNOD**

Employee Name: _____
(Please print clearly)

I understand that by waiving coverage I will not be eligible to enroll until the group's next open enrollment.

Please check the appropriate box or boxes below.

CHOOSE PLAN YOU ARE DECLINING

☐ I am waiving **BCBS MEDICAL/VISION** coverage from my employer.

☐ I am waiving **BCBS DENTAL** coverage from my employer.

COMPLETE THE FOLLOWING INFORMATION

I am covered under another group health plan, vision plan or dental plan.

Carrier Name:_____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

Carrier Name:_____ Policy/Contract Number: _____

Policyholder Name: _____ Relationship to Employee: _____

The information provided above is true and accurate to the best of my knowledge.

EMPLOYEE SIGNATURE _____ DATE: _____

JOB TITLE: _____

DATE OF HIRE: _____