

WAIVER OF ENROLLMENT (for group use only)

The group insurance program has been offered to me, and I am waiving my right to participate because:

HEALTH/RX

- I am covered by my spouse or parent's insurance program which includes:
 Health/RX Only Dental Only Health/RX and Dental

Spouse or Parent's Name: _____ Plan ID #: _____

Place of Employment: _____

Name of Insurance Company: _____

- I do not desire to enroll in Blue Cross and Blue Shield of Kansas coverage at this time and have no other insurance.
 Other (Please specify): _____

Notice of Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan following a triggering event. Check with your group leader for details.

Employee Signature: _____ Employee Name (please print): _____

Employer Name: USD 383 Manhattan Ogden Group #: 09624 Date: _____

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Independent licensees of the Blue Cross Blue Shield Association.

