



Anthem[®]Life



An Anthem Company

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Waiver of Insurance

Check coverage(s) that apply(ies): Health Dental Vision Life

THIS SECTION MUST BE COMPLETED

Social Security Number

Grid for Social Security Number (9 boxes)

Health Group Number

Grid for Health Group Number (10 boxes)

Dental/Vision Group Number

Grid for Dental/Vision Group Number (10 boxes)

Life Group Number

Grid for Life Group Number (10 boxes)

Employee Name (First, Middle Initial, Last)

Grid for Employee Name (24 boxes)

Full Company Name

Grid for Full Company Name (24 boxes)

WHO IS WAVING INSURANCE: (Check all that apply) EMPLOYEE SPOUSE CHILD(REN)

I/WE DO NOT WISH TO PARTICIPATE IN THE GROUP INSURANCE PLAN, AT THIS TIME, FOR THE FOLLOWING REASON(S):

- I have other group health insurance
 I have other individual health insurance
 I have other group dental insurance
 I have other group vision insurance
 I have other life insurance
 I have no other insurance coverage and I am not interested at this time
 I am a dependent of a uniformed serviceman, or am retired, or a dependent of a retiree, from military services

LIST ALL DEPENDENTS NOT PARTICIPATING IN GROUP COVERAGE INCLUDING SPOUSE

Table with 3 columns: DEPENDENT NAME (First, Middle Initial, Last), BIRTHDATE (MM/DD/YYYY), RELATIONSHIP

I hereby certify that I have been given the opportunity to participate in my Employer's Group Insurance Plan underwritten by the company(ies) indicated above. The plan has been explained to me and I decline to participate.

If I decline health coverage and have no other group or individual health coverage at this time, I understand my dependents and I may enroll as a late entrant(s) subject to an 18 month waiting period or at the group's anniversary date subject to an 18-month pre-existing condition waiting period, if applicable, or at the group's annual open enrollment, if available.

If I am declining enrollment for myself and/or my dependents (including my spouse) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

EMPLOYEE SIGNATURE

DATE

COLORADO AND NEVADA

The following statement only applies to fully insured groups in the state of Colorado, with 50 employees or less: COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.