# California Employee Waiver Form For Small Groups

Anthem

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

**Instructions:** Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

| Group/Case no. (if known) |
|---|
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## Section 1: Employee Information

| Last name | First name | M.I. | Social Security no.[1] |
|---|---|---|---|
| | | | |

| Home address — (P.O. Box not acceptable unless rural address) | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Employment status (required) ☐ Full-time ☐ Part-time | Hire date (required) (MM/DD/YYYY) | Requested effective date |
|---|---|---|
| | | |

Employer name

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

## Section 2: Waiver/Declining coverage —

Complete only if any coverage is declined or refused by you and/or your eligible dependents. Proof of coverage may be required.

| **Type of coverage/Declined for:** Select all that apply | | **Reason for declining/refusing coverage:** Select all that apply |
|---|---|---|
| ☐ Employee | ☐ Medical ☐ Dental ☐ Vision | ☐ No coverage<br>☐ Covered by Spouse's/Domestic Partner's group coverage<br>☐ Spouse/Domestic Partner covered by their employer's group coverage<br>☐ Enrolled in individual coverage<br>☐ Medicare/Medi-Cal/VA<br>☐ Enrolled in other Insurance — Please provide company name and plan: _____<br>☐ Other — please explain: _____ |
| ☐ Spouse/Domestic Partner | ☐ Medical ☐ Dental ☐ Vision | |
| ☐ Dependent(s) | ☐ Medical ☐ Dental ☐ Vision<br>List name of dependents to be waived: _____ | |

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, AND VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, AND VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, AND VISION INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

### Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

| Signature of applicant if declining coverage for yourself or dependents | Date (MM/DD/YYYY) |
|---|---|
| X | / / |

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.