

Independent Licensees of the Blue Cross and Blue Shield Association

DECLINATION OF COVERAGE

Name of Employee _____

Name of Current Employer _____

Please check appropriate boxes

I hereby acknowledge I have been offered group coverage under my employer's Regence BlueCross BlueShield of Oregon, Regence HMO Oregon or Regence Health Maintenance of Oregon, Inc. health plan(s) and I have declined coverage for:

- Myself
- Medical coverage
- Dental coverage
- Myself and my eligible family members
- Medical coverage
- Dental coverage

Coverage has been declined because I and/or my family members:

1. Do not wish coverage and do not have other medical / dental coverage
2. Have other group health coverage through my spouse's employer
 - Medical coverage
 - Dental coverage
3. Have individual medical coverage
4. Have Medicare coverage
5. Have other coverage

If you checked number 2, 3, 4 or 5, please complete the Coverage Information section below.
COVERAGE INFORMATION

POLICY NUMBER	ID NUMBER
NAME OF INSURANCE COMPANY	NAME OF SPOUSE'S EMPLOYER

If I (and/or my eligible dependents) choose to enroll at a later date, I agree to see my employer for enrollment instructions. I understand it may be up to one year before I am again eligible for coverage.

(Employee Signature)

(Date)

WHITE COPY - Regence BCBSO Marketing YELLOW COPY - Employer