



Please return this completed form to your employer.

If you **do not** choose to enroll in group coverage for yourself or your dependents, complete the following information and sign below.

Employer (group) name	Employee name (please print)
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Waiver of health and/or dental coverage: I certify that I have been given the opportunity to participate in my employer's group health and/or dental plan offered by Blue Cross and Blue Shield of New Mexico (BCBSNM). (Check the applicable boxes.)

Health <input type="checkbox"/> I do not elect health insurance plan coverage for myself and my dependents (if any). <input type="checkbox"/> I do not elect health insurance plan coverage for my spouse. <input type="checkbox"/> I do not elect health insurance plan coverage for my children.	Dental <input type="checkbox"/> I do not elect dental insurance plan coverage for myself and my dependents (if any). <input type="checkbox"/> I do not elect dental insurance plan coverage for my spouse. <input type="checkbox"/> I do not elect dental insurance plan coverage for my children.
Life <input type="checkbox"/> I do not elect life insurance plan coverage for myself and my dependents (if any).	

I do not wish to participate in the group insurance plan at this time, for the following reason:

<input type="checkbox"/> I have BCBSNM group coverage through another source; group name and number: _____	<input type="checkbox"/> I am retired (or a dependent of a retiree from Military Service).
<input type="checkbox"/> I have BCBSNM individual plan coverage.	<input type="checkbox"/> I am a dependent of a Uniformed Serviceman.
<input type="checkbox"/> I have other individual plan coverage; carrier name: _____	<input type="checkbox"/> I have no other coverage and am not interested at this time.
<input type="checkbox"/> I have other group coverage; carrier name: _____	

Employee Signature	Date
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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, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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