



Blue Cross  
Blue Shield  
of Michigan

An Independent Licensee of  
the Blue Cross Blue Shield  
Association

# Employee Waiver Form

Group Name: Crestwood School District

BCBSM – Group Number/Suffix 68239 BCN – Group ID, Class ID, Sub Group ID \_\_\_\_\_

Please check the appropriate box below and provide all applicable information:

Employee Name: \_\_\_\_\_  
(Please Print)

*I hereby waive BCBSM and BCN coverage offered by this employer for the following reason:*

- I have my own individual coverage. The information for this coverage is as follows:

\_\_\_\_\_  
Carrier Name Policy/Contract Number

- I am covered under another group health plan or dental plan not offered by this employer (spouse, self, parent, etc.). The information for this coverage is as follows:

\_\_\_\_\_  
Carrier Name Policy/Contract Number

\_\_\_\_\_  
Policyholder Name Relationship to Employee

*The information printed above is true and accurate to the best of my knowledge.*

\_\_\_\_\_  
Employee Signature Date

\_\_\_\_\_  
Employer Signature Date