WAIVER FORM

<table>
<tr><td colspan="2">Group Name</td><td colspan="2">Group Number</td></tr>
<tr><td colspan="2">Employee Name</td><td colspan="2">Employee Social Security Number</td></tr>
<tr><td rowspan="2">Employee Date of Birth</td><td>Sex</td><td colspan="2">Marital Status</td></tr>
<tr><td>❒ Male ❒ Female</td><td colspan="2">❒ Married ❒ Single</td></tr>
<tr><td colspan="2">Coverage Declined</td><td colspan="2"># Hours Worked Per Week</td></tr>
<tr><td colspan="2">❒ Medical ❒ Dental</td><td colspan="2"></td></tr>
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I have been offered coverage under this group's Regence BlueShield and/or RegenceCare plan, but I am declining coverage for the following reason:

- ❒ I am covered by TRICARE (CHAMPUS).
- ❒ I am covered by Medicare as primary, at the request of the Medicare enrollee.
- ❒ I am covered by another group health plan through a spouse or parent.
  (Group Employer Name ____)

If you have checked any of the above, please attach evidence of other coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or similar proof. Please note that enrollment in an individual health plan is not a valid reason to waive off this group coverage.

Our Company participation requirements mandate the enrollment of all eligible employees in both their employer's medical and/or dental coverage issued through our Company. The cost of the coverage is not a valid reason for an eligible employee to decline to enroll in coverage. Please contact your Group Administrator if you have any questions regarding your eligibility status.

If you are declining coverage under this medical/dental plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may under certain circumstances be able to enroll yourself or your dependents under this plan in the future, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you decline enrollment under this medical plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under this plan, provided that you request enrollment within 31 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. However, if you voluntarily end your other coverage after declining this coverage, you and your dependents may not be eligible to enroll in this plan until the next open enrollment period. Please contact your Group Administrator or our Member Services Department if you require further information.

I understand that I and/or any of my dependents will be unable to obtain coverage under this group's Regence BlueShield and/or RegenceCare plan until the next open enrollment period, unless I and/or my dependents qualify for enrollment under the aforementioned special enrollment rules.

____ Employee Signature

____ Date