Partial Waiver

Please submit completed form to BBD:
500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
Fax: 604.464.7997 Toll Free: 800.667.1336

Name of Employer:

▶ ***To use this form you must already be insured under your employer's plan.*** ◀
▶ ***For a new enrollment complete a Group Insurance Enrollment form.*** ◀

▶ Employee – Complete for partial waiver due to coverage under another group plan ◀

Employee Last Name	First Name	Initial	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)

▶ For myself and my dependents……☐ Extended Health Care ☐ Dental Care **OR** ▶ For my dependents only ....☐ Extended Health Care ☐ Dental Care

Name of Other Plan's Employer/Policyholder		Is this your spouse's group plan? ☐ Yes ☐ No (if no, provide details)
Name of Insurance Company		___________________________
Group Number	Identity Number	___________________________

05-2010