KAISER PERMANENTE®

Small Business

DECLINATION OF COVERAGE

Employee name (please print): _____

INSTRUCTIONS

Please use this form to decline coverage, not to terminate a subscriber or member. If you would like to terminate a subscriber or member, please use the Subscriber Termination/Transfer Form.

Employers: Keep a copy of this form for your records.

COMPANY INFORMATION

Company name			Customer ID (if assigned)	
Street address (no P.O. boxes)	City	State	ZIP	County
Office phone ( ) –	Ext.	Fax ( ) –		
Email				

REASON FOR DECLINING

I have been offered Kaiser Permanente group health coverage by my employer. I voluntarily choose not to enroll myself in a Kaiser Permanente plan at this time. I understand that the next opportunity to enroll will be during the annual open enrollment period.

Reason for declining (check one):

☐ I am covered by another employer's health plan through my spouse/domestic partner/parent.
Name of carrier:

☐ I am covered by another plan offered by my employer.
Name of carrier:

☐ I am covered by an individual health plan.
Name of carrier:

☐ I am covered by Medicare, Medi-Cal, or Tricare.

☐ Other reason for declining:

SIGNATURE

If you decline coverage for yourself or an eligible dependent, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or, during a special enrollment period if you have experienced a qualifying event. You must request coverage within 30 days of a qualifying event. Special enrollment qualifying events include:

- Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility
- Return from a leave of absence
- Involuntary termination or loss of other group coverage
- A dependent loses coverage elsewhere
- Marriage or addition of a domestic partner
- Birth
- Adoption of a child or placement for adoption
- Court order
- Death of a spouse, domestic partner, or dependent

Employee name (please print)	Social Security number (last 4 digits)
Signature **X**	Date