KAISER PERMANENTE®

DECLINATION OF COVERAGE

I have been offered group health coverage through Kaiser Foundation Health Plan, Inc., (Health Plan) by my employer, _____. Purchaser Number _____.

I voluntarily choose not to enroll in Health Plan through my employer at this time. I understand my next opportunity to enroll myself or my eligible dependents will be during the open enrollment period in _____ (month/year), with coverage effective in _____ (month/year). Health Plan's *Evidence of Coverage* also informs the group of my enrollment rights due to: (1) Special Enrollment due to new Dependents, and (2) Special Enrollment due to loss of other coverage.

Print employee name	Employee's signature	Social Security number	Date	Reason (must check one box)
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
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		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage
		– –		❑ I am covered by other group insurance ❑ I decline employer-sponsored health coverage