KAISER PERMANENTE®

DECLINATION OF COVERAGE

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

I voluntarily choose not to enroll in the 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. The 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's 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.
		– –		❑ 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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