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
Office phone ( ) –	Ext.	Fax ( ) –	

REASON FOR DECLINING

I have been offered Kaiser Permanente group health coverage by my employer. I voluntarily choose not to enroll myself and my dependents 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

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

You may be eligible to enroll yourself and your dependents before the next open enrollment period if a qualifying event, such as losing other coverage, occurs. If your situation changes, please contact your employer immediately for more information.