KAISER PERMANENTE®

Small Business

DECLINATION OF COVERAGE

IMPORTANT INFORMATION

Employees and owners: Please use this form only to decline group health coverage.

Employers: Keep a copy of this form for your records. Ensure name of carrier field is completed to avoid processing delays. If you would like to terminate a subscriber or member, please use the Subscriber Termination/Transfer Form.

1 COMPANY INFORMATION

Company name	Customer ID (if assigned)

2 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 or after a qualifying event.

Declination reason and carrier name impact the 70% participation requirement. **Only group coverage counts toward the participation requirement.**

Reason for declining (check 1):

☐ 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 the employer listed above or another employer I work for.

Name of carrier:

☐ I am covered by an individual health plan.

Name of carrier:

☐ I am covered by Medicare, Medi-Cal, or Tricare (military or VA benefits).

☐ Other reason for declining:

Note: Name of carrier field must be completed.

3 SIGNATURE

If you decline coverage for yourself, you're also declining coverage for your eligible dependent(s). 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 60 days of a qualifying event. Special enrollment qualifying events include:

- Increase in your hours so that you meet your employer's 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