

**INSTRUCTIONS**

Please use this form only to decline coverage. 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)
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 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.

Reason for declining (check 1):

<input type="checkbox"/> I am covered by another employer's health plan through my spouse/domestic partner/parent.
<b>Name of carrier:</b>
<input type="checkbox"/> I am covered by another plan offered by my employer.
<b>Name of carrier:</b>
<input type="checkbox"/> I am covered by an individual health plan.
<b>Name of carrier:</b>
<input type="checkbox"/> I am covered by Medicare, Medi-Cal, or Tricare.
<input type="checkbox"/> 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 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 <b>X</b>	Date