KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Portland, OR 97232.

Oregon Small Business

EMPLOYEE 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.

1 COMPANY INFORMATION

Company name	Group number (if assigned)

2 REASON FOR DECLINING

I've 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. **Check one:** ☐ Medical ☐ Dental ☐ Both

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 one):

☐ I'm covered by another group health benefit plan.

☐ I'm covered by another plan offered by Medicare, Medicaid, TRICARE (military or VA benefits), Indian Health Service, or a publicly sponsored or subsidized health benefit plan including, but not limited to, the medical assistance program under ORS Chapter 414.

☐ I'm covered by an individual health plan.

☐ Other reason for declining (specify reason):

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've 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