Waiver of group insurance

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stopped contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. You must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, call your employer or Kaiser Permanente's Member Services at 1-800-813-2000. For TTY, call 711. For language interpretation services, call 1-800-324-8010. Member Services staff are available Monday through Friday, 8 a.m. to 6 p.m.

Please check the appropriate boxes and fill in **all** blanks. *(Indicate "N/A" if not applicable.)*

Employer name _____ Group no. _____

Employee name _____

Type of waiver:
- ☐ Medical
- ☐ Dental

People waiving:
- ☐ I decline enrollment in Kaiser Foundation Health Plan of the Northwest for myself and my dependents.
- ☐ I decline enrollment in Kaiser Foundation Health Plan of the Northwest for the following dependents only:

_____ _____

_____ _____

Reason for waiving:
- ☐ Other group coverage
- ☐ Other individual coverage purchased directly through Kaiser Permanente or another health plan provider
- ☐ Other individual coverage purchased through the Health Insurance Marketplace (also known as Exchanges)

My and/or my dependents' insurance carrier is _____ (insurance company)

(policy number) _____ , through _____ (employer or individual).

I understand I will not be eligible to enroll myself or my dependents until the next open enrollment, unless I meet the requirements for a special enrollment.

Employee signature _____ Date _____

Employer: Please keep a copy for your records.

KAISER PERMANENTE®

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