KAISER PERMANENTE®

Small Business

DECLINATION OF COVERAGE

(Employer Attestation)

IMPORTANT INFORMATION

Please use this form to list your employees who have declined coverage. If employees have filled out the Waiver of Coverage form, please transfer their information onto the list below and submit to your Kaiser representative. Keep a copy of this form for your records. **To terminate a subscriber, please use the Subscriber Termination, Transfer, and Reinstatement form.**

1 COMPANY INFORMATION

Company name	Group ID (if assigned)

2 REASONS FOR DECLINING

Kaiser Permanente group health coverage has been offered to the eligible employees listed below. These employees have voluntarily chosen not to enroll in a Kaiser Permanente plan at this time for one of the following reasons:

1. Covered by another employer's health plan through a spouse, domestic partner, or parent
2. Covered by another health plan offered by this employer
3. Covered by another employer they work for
4. Group coverage through COBRA or Cal-COBRA
5. Covered by Medicare, Medi-Cal, or TRICARE (military or VA benefits)
6. Covered by an individual health plan
7. Not interested in enrolling at this time

Avoid processing delays by assuring the reason code is completed below. **Use reason codes 1–7 listed above.**

First name	Last name	**Reason code (required)**

To list additional employees, please make copies of this form, as needed. All copies of this form must be signed.

Groups enrolling during Guaranteed Availability (November 15–December 15) are exempt from completing the required reason code above and meeting participation and contribution requirements.

Please note: Groups enrolling under Guaranteed Availability may be flagged to undergo recertification and will be required to meet all underwriting criteria, including participation and contribution requirements, at that time.

3 READ AND SIGN

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company on behalf of the group. I understand that the next opportunity to enroll will be during the annual open enrollment period or after a qualifying event.

Authorized company signer (please print name)	Company title (please print)
Signature X	Date