KAISER PERMANENTE®

# WAIVER OF GROUP MEDICAL COVERAGE

| EMPLOYEE NAME (PLEASE PRINT) | SSN |
|---|---|
| | |
| **GROUP NAME** | **GROUP NUMBER** |
| | |

## A. I WAIVE COVERAGE FOR (Check ALL boxes which apply):

- ☐ MYSELF
- ☐ SPOUSE — Spouse's Name: _____
- ☐ CHILD(REN) — Child(ren)'s Name(s): _____

## B. REASON FOR WAIVING COVERAGE:

- ☐ Covered under another employer-sponsored Health Plan:
  - Person through who I am covered: _____
  - Employer: _____
  - Carrier: _____
- ☐ Other (explain): _____

I understand that if I waive coverage for myself and/or my dependents during the open enrollment period and later request coverage, Kaiser Foundation Health Plan may exclude us until the next open enrollment (which may be up to 12 months away) UNLESS one of the Late Entrant Exceptions applies as described below, and I furnish any required information as proof.

**LATE ENTRANT EXCEPTIONS:**

Employees and their dependents will be eligible for late entry if one of these circumstances applies:

1. Termination of other health coverage:
   a. this waiver of group medical coverage form is completed and signed, and
   b. enrollment under this plan was initially declined solely due to other coverage, and
   c. request for enrollment in KFHP is made within 30 days after termination of other coverage, and
   d. termination of the other coverage is due to:
      - termination of employment
      - change in employment terms
      - termination of the other group coverage
      - cessation of the other employer's contribution toward coverage
      - divorce or death of the person through whom I am covered as a dependent
2. Court Order: A request for enrollment is made within 30 days after issuance of a court order that coverage be provided for the spouse and/or minor children of a covered employee.

| SIGNATURE OF EMPLOYEE | DATE |
|---|---|
| | |