Health Insurance Waiver Form

For coverage effective 12/1/2020-11/30/2021

For plan: Kaiser Permanente: Bronze HMO 6300/65+ Child Dental

A. Please check the box which identifies the coverage you wish to decline: Medical ☐

B. I would like to decline coverage for: Employee ☐ Spouse ☐ Dependent children ☐ Spouse and children ☐

C. Reason for declining coverage: (Check one)

☐	Covered by spouse's group insurance
☐	Carrier Name: _____ I.D.Number: _____
☐	Enrolled in any other insurance carrier plan
☐	Carrier Name: _____
☐	Military
☐	Medicare
☐	Other (Explain): _____

I acknowledge that the available coverage has been explained to me by my employer and I understand that I have every right to apply for coverage. I have been provided the opportunity to apply for this coverage and I have declined to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily. **BY DECLINING THIS GROUP HEALTH COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP HEALTH COVERAGE ELSEWHERE), I ACKNOWLEDGE IF WE APPLY FOR COVERAGE AFTER OUR ORGINAL ELIGIBLITY DATE FOR THIS INSURANCE, MY DEPENDENT(S) AND I MAY BE CONSIDERED LATE ENTRANT(S) AND THEREFORE NOT ELIGIBLE UNTIL THE NEXT OPEN ENROLLMENT.**

You will not be considered a late enrollee if:

1. You or your waiving dependents were covered under another health plan at the time of this waiver; and you execute this form at the time of waiving coverage;
   a) You have lost coverage under another health plan as a result of: I) termination of employment; II) change in employment status; III) termination of the other plan's coverage; IV) cessation of an employer's premium contribution toward an employee's or dependent's coverage; or death of the individual through which the waiving individual was covered as a dependent, or divorce, and
   b) You request enrollment within 30 days after termination of coverage or Employer contribution under another employer health benefit plan; or,
2. A court orders coverage be provided for a spouse or child of an insured Employee and request for enrollment under this plan is made within 30 days of the issuance of the court order; or,
3. He or she is employed by an Employer that offers multiple health plans and the Employee elects a different plan during an open enrollment period.

Employee Signature: _____ **Date:** _____

Print Employee Name: _____