
Large Group Solutions

Waiver of health coverage

I acknowledge that I have been offered the opportunity to purchase health coverage from Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. for myself and my dependents through my employer.

I decline enrollment at this time because:

I have other medical coverage provided by:

Insurance company name: _____ Policy number: _____

Through (employer or organization name): _____

I do not wish to enroll myself in any type of medical coverage at this time.

I do not wish to enroll my spouse child(ren) in any type of medical coverage at this time.

If you are declining enrollment for yourself or dependents (including your spouse) you may enroll yourself or your dependents in this plan prior to the next open enrollment period under certain circumstances. To do this, we must receive your enrollment application no more than 60 days from most qualifying events. In the event of marriage, we must receive your enrollment application within 31 days of the marriage.

Printed name: _____

Signature: _____ Date: _____

Name of employer: _____