



WAIVER OF HEALTH BENEFITS

Name of Employer _____

Name of Employee _____
(Please print or type)

I certify that:

- 1) I was given the opportunity to apply for group health benefits offered by my employer through Kaiser Permanente,

and

- 2) I waive coverage for: Myself and my dependents My dependents only

Current Health Coverage Status:

Covered through another Kaiser Permanente Plan

Covered through my spouse's employer Spouse's Company Name _____
Spouse's Name _____

No Coverage

Other _____

By signing this waiver to decline coverage, I understand that any later application for enrollment and acceptance will be subject to all underwriting requirements.

Print Name _____ SS# _____

Signature _____ Date _____