HEALTHSPAN | *Care and Coverage formerly by Kaiser Permanente*

Kaiser Permanente Insurance Company

OHIO REGION
Employee Enrollment/Change Form

WAIVER OF ALL COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer.

I refuse the following:

☐ All coverage

Reason for refusal:

☐ Other group coverage sponsored by my spouse's employer

☐ Other reasons (please explain)_____

Please provide name of carrier: _____

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit a Group Employee Enrollment and Change Form, and enrollment can occur only at open enrollment unless the late enrollee provisions apply.

EMPLOYER/GROUP NAME

GROUP NO

EMPLOYEE NAME)

LAST 4 OF SOCIAL SECURITY

EFFECTIVE DATE (MM/DD/YYYY

Employee Signature

_____

Date