KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Portland, OR 97232.

Small Group

OREGON EMPLOYER ATTESTATION DECLINATION OF COVERAGE

IMPORTANT INFORMATION

Please use this form to list your employees who have declined coverage. Keep a copy of this form for your records.

1 COMPANY INFORMATION

Company name	Group number (if assigned)

2 REASONS FOR DECLINING COVERAGE

Kaiser Permanente group health coverage has been offered to the eligible employees listed below. These employees have voluntarily chosen not to enroll in a Kaiser Permanente plan at this time for one of the following reasons:

1. Covered by another group health benefit plan
2. Covered by Medicare, Medicaid, TRICARE, Indian Health Service, or a publicly sponsored or medical assistance program under ORS Chapter 414
3. Covered by an individual health plan
4. Not interested in enrolling at this time

Avoid processing delays by assuring the reason code is completed below. **Use reason codes 1–4 listed above.**

First name	Last name	Medical, dental, or both?	**Reason code***

To list additional employees, please make copies of this form, as needed.

*Required field. Use reason codes 1–4 listed above.

Groups enrolling during Guaranteed Availability (November 15–December 15) are exempt from completing the required reason code above and meeting participation and contribution requirements.

3 PEDIATRIC DENTAL DECLINATION OF COVERAGE

Kaiser Permanente pediatric dental coverage has been offered to the eligible employees below. These employees voluntarily chose not to enroll their dependent(s) under age 19 because they have pediatric dental coverage elsewhere that is compliant with the Essential Health Benefits provision of the Affordable Care Act.

First name	Last name

4 SIGNATURE

I understand that the next opportunity to enroll will be during the annual open enrollment period or after a qualifying event. I affirm that I am the contract signer and have authority to make membership or contractual changes to our account with Kaiser Foundation Health Plan of the Northwest on behalf of the group.

Authorized company signer (please print name)	Title (please print)
Signature X	Date