PERMANENTE MEDICINE®
Southern California
Permanente Medical Group

Southern California Permanente Medical Group (SCPMG) Supplemental Medical Insurance Request to Waive Coverage Form

Last Name	First Name	Middle Name
Street Address, City, State, Zip Code		Last 4 Digits of SSN

Please sign the bottom of this form to acknowledge you are waiving coverage:

☒ **I elect to waive the SCPMG Supplemental Medical Insurance**

If you waive your supplemental medical insurance coverage, you will not incur imputed income for the supplemental medical insurance coverage.

You may only re-enroll into the supplemental medical insurance during the fall Open Enrollment or if you experience loss of coverage of another health plan. The policy will take effect the first day of the month following receipt of your properly completed enrollment form and any necessary documentation.

Coverage will be discontinued on the first day of the month following receipt of your properly completed Request to Waive Coverage Form and any other necessary forms. If you have questions on the completion of this form, please contact PHR Shared Services at 1-877-608-0044, or phrsharedservices@kp.org.

X_____ _____
Signature **Date**

Your address, only if different from above:

_____ _____
Street address City, State, Zip Code

Email Address: _____

Return completed form to:
PHR Shared Services: PHRSharedServices@kp.org
Southern California Permanente Medical Group c/o PHR Benefits Department
393 E. Walnut Street, 3rd Floor Pasadena, CA 91188
Phone: 1-877-608-0044 | Secure Fax: (626) 628-3789

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