COVERAGE WAIVER
MEDICAL / DENTAL

WAIVER OF MEDICAL PLAN COVERAGE

I am declining coverage under the company's Medical Plan. By taking this action I understand that as of the beginning of the next plan year (or eligibility date if I am a newly hired employee), I will not be eligible to file claims under the plan for myself and/or my dependents.

I also understand that if I rejoin the company's Medical Plan at a future date, I and my eligible covered dependents, if applicable, will be subject to a pre-existing restriction in the plan that may limit or reduce the amount of coverage/reimbursement available.

I am married ☐ Yes ☐ No ***(If yes, spouse must also sign)***

Employee's Printed Name	Soc. Sec. No.	Employee's Signature	Date
Spouse's Printed Name	Soc. Sec. No.	Spouse's Signature	Date

WAIVER OF DENTAL PLAN COVERAGE

I am declining coverage under the company's Dental Plan. By taking this action I understand that as of the beginning of the next plan year (or eligibility date if I am a newly hired employee), I will not be eligible to file claims under the plan for myself and/or my dependents.

I am married ☐ Yes ☐ No ***(If yes, spouse must also sign)***

Employee's Printed Name	Soc. Sec. No.	Employee's Signature	Date
Spouse's Printed Name	Soc. Sec. No.	Spouse's Signature	Date

PLEASE RETURN THIS FORM TO:

Kinder Morgan
Attn: Benefit Department
500 Dallas, Suite 1000
Houston, TX 77002