KAISER PERMANENTE®

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse *before* completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER

Company name		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment or coverage date (mm/dd/yyyy)

NEW ENROLLMENT *Check one:*

❑ New hire *(complete sections A, B, C, D)*
❑ Open enrollment *(complete sections A, B, C, D)*
❑ New group
❑ Other coverage loss *(complete sections A, B, C, D)*
❑ Other *(please specify)* ______________________
Event date (mm/dd/yyyy) ______________________

PLAN *Check one:* ❑ HMO ❑ Deductible Plan ❑ Other ______________________

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

❑ **Add** dependents *(complete sections A, B, D)* ❑ **Delete** dependents *(complete sections A, B, D)*
*Reason: *(see Change Table)* Event date (mm/dd/yyyy)
❑ **Name change** *(complete sections A, B, D)* From: ______________ To: ______________
❑ **Address change** *(complete section A)* ❑ **Telephone change** *(complete section A)*

A. EMPLOYEE

Medical record no. *(if known)*		Social Security no.		
Name **(Last, First, MI)**		Birth date (mm/dd/yyyy)		Gender ❑ M ❑ F
Home address	Apt. no.	City	State	ZIP
Work phone	Home phone	E-mail		
Preferred spoken or written language		Ethnicity		

B. FAMILY
For additional dependents, attach a separate sheet with employee's name at top. **(Last, First, MI)**

❑ Add ❑ Delete	❑ Spouse ❑ Domestic partner	Gender ❑ M ❑ F	Social Security no.
Spouse/Domestic partner name:			Birth date (mm/dd/yyyy)
Former last name *(if any)*:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:
Name **(Last, First, MI):** Address:

C. OTHER COVERAGE
Including yourself, do any of the persons listed above have other coverage? ❑ Yes ❑ No

Name	Insurance carrier name		Policy no./Effective date	Phone no.

D. <u>Kaiser Foundation Health Plan Arbitration Agreement</u>: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee/Applicant signature Date	Employer signature Date

*Additional documentation may be required.

White copy – Kaiser Permanente **Yellow copy – Employer** **Pink copy – Employee**

General Instructions:

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A through C. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscribers should retain the last copy for their records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates, as they affect the Health Plan dues.

If making a change, the subscriber must always complete this section, even when making minor changes to the account so our information is current. Please mark the box if your address is new.

Section A: The subscriber must complete this section.

Section B: The subscribers must indicate the requested change they are making to their account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* Form may be required.

Sections C, D: The subscriber must complete these sections.

Change Table

Add dependent	**Event date**
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)*	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent	**Event date**
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

*Additional documentation may be required.