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 _____ Date of hire _____

Group number _____ Enrollment unit _____ Effective date of enrollment or coverage _____

NEW ENROLLMENT *Check one:*

❑ New purchaser
❑ New hire *(complete sections A, B, C, D)*
❑ Loss of other coverage *(complete sections A, B, C, D)*
❑ Open enrollment *(complete sections A, B, C, D)*
❑ Other *(please specify)* _____
Date of event _____

PLAN *Check one:* ❑ HMO ❑ Deductible Plan

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

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

A. EMPLOYEE INFORMATION

Name (Last, First, MI) _____ Former last name *(if any)* _____

Home address _____ Apt. no. _____ City _____ State _____ ZIP _____

Home phone _____ Work phone _____ Medical Record no. *(if known)* _____

❑ M ❑ F
Gender _____ E-mail _____ Social Security no. _____

Date of birth _____ Preferred spoken or written language *(optional)* _____ Ethnicity *(optional)* _____

B. FAMILY INFORMATION

For additional dependents, attach a separate sheet and please put the employee's name at the top. (Last, First, MI)

❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner Spouse/Domestic partner name: Former last name *(if any)*:	Gender ❑ M ❑ F Date of birth	Social Security number Medical Record number
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F Date of birth	Social Security number Medical Record number
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F Date of birth	Social Security number Medical Record number

Do any of your dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name(s) (Last, First, MI):	Address:

C. OTHER COVERAGE INFORMATION:

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 Employee Retirement Income Security Act regarding 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, 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**

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General instructions:

1. Please print firmly and legibly in black ink.
2. To be enrolled, you must reside within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section labeled "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 completed employer section), the subscriber should retain the last copy for their records 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 reason 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. This ensures our information is current. Please mark the box if your address is new.

Section A: The subscriber must complete this section.

Section B: The subscriber 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 their rules for overage dependent students. A completed *Student Certification* Form may be required.

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

Change Reason Table

Add dependent reason	**Event date**
Acquired student status*	Date student status was obtained
Family adoption*	Date of adoption
Loss of coverage	Date coverage was lost
New spouse (marriage)*	Date of marriage
Moved into service area	Move date
Newborn addition	Date of birth
Open enrollment	Open enrollment effective date

Delete dependent reason	**Event date**
Loss of student status	Date of status change
Divorce	Date of divorce
Member deceased*	Date of death
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

*Additional documentation may be required.