

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name

Hire date (mm/dd/yyyy)

Group number

Enrollment unit

Effective enrollment/
change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance)

New group: Yes No

New Hire (complete sections A, B, C, D)

Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) HMO Plan Deductible Plan Other _____

Loss of Other Coverage (complete sections A, B, C, D)

Other (please specify) _____

Name change (complete sections A, B, C, D) From: _____

To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known) _____

Social Security No. _____

Name (Last, First, MI) _____

Birth Date (mm/dd/yyyy) _____

Gender M F

Home Address _____

City _____

State _____

ZIP _____

Work Phone _____

Home Phone _____

E-mail _____

Ethnicity _____

Preferred Language _____

C. 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. _____

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

Name (Last, First, MI): _____

Address: _____

D. Kaiser Foundation Health Plan Arbitration Agreement: 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, relatives, 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 our 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.

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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 and B. 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 subscriber should make a copy for his or her 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.

Section A: The subscriber must complete this section.

Section B: The subscriber must always complete this section. Use the Change Table (below) for assistance.

Section C: The subscriber must indicate the requested change to the 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 be marked only 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.

Section D: The subscriber must sign and date this section.

Change Table

Add dependent

Acquired student status*

Family adoption*

Loss of coverage

New spouse (marriage)

Moved into service area

Newborn addition

Open enrollment

Event date

Student status date

Adoption date

Coverage loss date

Marriage date

Move date

Birth date

Open enrollment effective date

Delete dependent

Loss of student status

Divorce

Member deceased*

Delete dependent(s)

Open enrollment

Event date

Status change date

Divorce date

Death date

Dependent termination date

Open enrollment effective date

Demographic Change

Address change, telephone number change

Demographic (name, birthdate, social security number) change

Event date

Status change date

Status change date

*Additional documentation may be required.