

Enrollment 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	Date of hire	
Group number	Enrollment unit	Effective date of enrollment or coverage

NEW ENROLLMENT *Check one:*

<input type="checkbox"/> New purchaser	<input type="checkbox"/> Open enrollment (complete sections A, B, C, D)
<input type="checkbox"/> New hire (complete sections A, B, C, D)	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Loss of other coverage (complete sections A, B, C, D)	Date of event _____

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

<input type="checkbox"/> Add dependents (complete sections A, B, D)	<input type="checkbox"/> Delete dependents (complete sections A, B, D)
*Reason: _____ (see Change Reason Table)	Event date: _____
<input type="checkbox"/> Name change (complete sections A, B, D) From: _____ To: _____	
<input type="checkbox"/> Address (complete section A) _____	
<input type="checkbox"/> 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 number (if known)		
<input type="checkbox"/> M <input type="checkbox"/> F Gender	E-mail	Social Security number		
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)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Spouse/Domestic partner name:	Date of birth MM/DD/YY	Medical record number
Former last name (if any):		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Dependent name:	Date of birth MM/DD/YY	Medical record number
Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Dependent name:	Date of birth MM/DD/YY	Medical record number
Relationship:		

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

Name(s) (Last, First, MI):	Address:
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C. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? Yes No

Name	Insurance carrier name	Policy number/Effective date	Phone number
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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 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 (optional)	Date
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*Additional documentation may be required.

Enrollment Form

General instructions:

1. Please print legibly in black ink.
2. To be enrolled, you must live or work within one of the ZIP codes listed in the "Enrollment" section of this booklet.
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 make a copy for his/her records to use with the Temporary Membership ID, 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.