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. 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 _____ Date _____

*Additional documentation may be required.