

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> New Hire (complete sections A, B, C, D)		<input type="checkbox"/> Open Enrollment (complete sections A, B, C, D)	
Health Plan (Check one) <input type="checkbox"/> HMO Plan <input type="checkbox"/> Deductible Plan <input type="checkbox"/> Other _____			
<input type="checkbox"/> Loss of Other Coverage (complete sections A, B, C, D)		<input type="checkbox"/> Other (please specify) _____	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Record No. (if known)	Social Security No.		
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)		Gender <input type="checkbox"/> M <input type="checkbox"/> 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)			
<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 No.	
Spouse/domestic partner name:		Birth Date (mm/dd/yyyy)	
Former last name (if any):		Medical Record No.	
<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 No.	
Dependent name:		Birth Date (mm/dd/yyyy)	
Relationship:		Medical Record No.	
<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 No.	
Dependent name:		Birth Date (mm/dd/yyyy)	
Relationship:		Medical Record No.	
Do any of dependents above live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:			
Name (Last, First, MI): Address:			
D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*:			
<p>I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, 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 <i>Evidence of Coverage</i> and in the <i>Certificate of Insurance</i>.</p>			
<p>* Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC dental plans.</p>			
Employee/Applicant signature	Date	Employer signature	Date

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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

	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

Demographic Change

	Event date
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.