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		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment or coverage date (mm/dd/yyyy)

NEW ENROLLMENT *Check one:*

❑ New hire *(complete sections A, B, C, D)*
❑ Open enrollment *(complete sections A, B, C, D)*
❑ New group
❑ Other coverage loss *(complete sections A, B, C, D)*
❑ Other *(please specify)* ______
Event date (mm/dd/yyyy) ______

PLAN *Check one:* ❑ HMO ❑ Deductible Plan ❑ Other ______

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

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

A. EMPLOYEE

Medical record no. *(if known)*			Social Security no.		
Name **(Last, First, MI)**			Birth date (mm/dd/yyyy)		Gender ❑ M ❑ F
Home address	Apt. no.	City		State	ZIP
Work phone	Home phone		E-mail		
Preferred spoken or written language			Ethnicity		

B. 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.
❑ 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:

C. OTHER COVERAGE 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 ERISA, 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 (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 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**