KAISER PERMANENTE®

Enrollment Application

Please print or type in black ink only. Please see instructions on reverse *before* completing this form. Retain last copy for your records and use as a temporary ID after the effective date. Fields with * are mandatory for enrollment.

A. TO BE COMPLETED BY EMPLOYER

*Company or Trust Fund Name | *Purchaser Number | *Enrollment Unit Number (EU)

Company or Trust Fund Address | (____) ____ Phone Number | (____) ____ Fax Number

Purchaser Contact | Employer ID | *Effective Date of Coverage

***ENROLLMENT (check only one—see Enrollment Reason Table on reverse side for options)**

❑ New Hire Enrollment—Date of Hire: _____
❑ Part Time to Full Time—Date: _____
❑ New Purchaser
❑ Open Enrollment
❑ Other: _____ Event Date: _____

B. EMPLOYEE/SUBSCRIBER INFORMATION

Are you now or have you ever been a Kaiser Permanente member? ❑ Yes ❑ No
If so, what is/was your Medical Record Number? _____
Have you ever received care from Kaiser Permanente within the state of California? ❑ Yes ❑ No
Under what name: _____
Maiden/Other

___-___-___ *Social Security Number | *Last Name | *First Name | MI

*Date of Birth: ____/____/____ | *Gender: ❑ M ❑ F | Marital Status: ❑ Married ❑ Single

Preferred Language Spoken | Preferred Language Written | E-mail Address (optional)

*Street Address | *City | *State | *ZIP Code

(____) ____ Day Phone ❑ Home ❑ Work | (____) ____ Evening Phone ❑ Home ❑ Work | Employee ID | Employment Status: ❑ Working ❑ Retired

C. LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed)

*Last Name	*First Name	MI	*Role	*Social Security Number	*Date of Birth MM/DD/YY	*Gender	Medical Record Number if Known
Spouse *Maiden/Other:*			❑ Spouse ❑ Domestic Partner	___-___-	/ /	❑ M ❑ F	
Dependent *Relationship:*			❑ Child ❑ Student	___-___-	/ /	❑ M ❑ F	
Dependent *Relationship:*			❑ Child ❑ Student	___-___-	/ /	❑ M ❑ F	
Dependent *Relationship:*			❑ Child ❑ Student	___-___-	/ /	❑ M ❑ F	
Dependent *Relationship:*			❑ Child ❑ Student	___-___-	/ /	❑ M ❑ F	

Dependent(s') Address (if different from subscriber's): ❑ Check here if all dependents are at the address below.

Name(s)	Address	City	State	ZIP Code

I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA 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 arbitration provision is contained in the *Evidence of Coverage*.

X _____ X _____

***Employee/Subscriber Signature** ***Date**

TOP COPY–To Kaiser Permanente (CSC) **MIDDLE COPY**–To be retained by purchaser **BOTTOM COPY–To be retained by subscriber**