

ENROLLMENT FORM

Please use black ink. See instructions on page 3 before completing this form. Make a copy for your records.

A To be completed by EMPLOYER New group account Existing group account

Company name¹ _____ Group number _____ Date coverage to be effective¹ ____/____/____

Enrollment unit _____ Plan selection _____ Employee classification (if applicable) _____

Employee name _____ Date of hire ____/____/____

Enrollment reason¹ (Please check one.)

New group account New hire Open enrollment Part-time to full-time ____/____/____
 Loss of coverage ____/____/____ Other _____ Event date ____/____/____

B To be completed by EMPLOYEE

Have you ever been a member of, or received care from, Kaiser Permanente in California? Yes No

If so, under what medical record number (if known)? _____ Former/Maiden name? _____

Name (Last, First, MI)¹ _____ Social Security number¹ _____ Preferred spoken or written language (optional) _____

Home address¹ _____ Apt no. _____ City¹ _____ State¹ _____ ZIP code¹ _____

____/____/____ Gender¹ M F Home phone¹ _____ Work phone _____

C Family information

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			

Will you be adding additional dependents? Yes No Add any additional dependents on page 2.

D Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement²:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes¹) 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 Evidence of Coverage and in the Certificate of Insurance.

X
Employee signature¹ (Use black ink.) _____ Date¹ _____

¹Required

²Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service Plans; 2) the PPO and Out-of-Area Indemnity Plans; and 3) the KPIC Dental Plans.

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If additional room for dependents is not needed, there is no need to complete or fax this page.

Employee name _____ Company name¹ _____ Date coverage to be effective¹ ____/____/____

Group number _____ Plan selection _____

E Family information (additional dependents)

<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child	Date of birth ¹ _____	Gender ¹ <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. ¹ _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			

¹Required

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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 your enrollment book (does not apply to enrollment in PPO plans).
3. The employer must complete section A, "To be completed by EMPLOYER."
4. The employer is responsible for confirming all information prior to submitting, especially effective date as this affects premiums.
5. The employee/subscriber must complete sections B through E.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), make a copy for your records to use with the *Temporary Membership ID Form* after the effective date.
8. All effective dates will be made in accordance with the contractual agreement between the purchaser (your employer) and Kaiser Permanente.

Instructions for completing sections A through E

Section A: 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 employee, especially effective date, as this affects premiums. The plan selection information requested is only needed if your group currently offers more than one Kaiser Permanente plan.

Section B: The employee must complete this section.

Section C: The employee must 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. For additional dependents, please use an additional sheet of paper. For disabled dependents, call **1-800-731-4661**, extension **3584**.

Section D: The employee must read this section, and sign and date at the bottom.

Section E: The employee must complete this section only if needed to list additional dependents.