California Region Kaiser Permanente 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:		
District Name:		Hire Date (mm/dd/yyyy)
District Name.		
Medical Group Number:	inrollment Unit:	Effective Enrollment/ Change Date (mm/dd/yyyy)
Complete this section ONLY if dental, vision and/or life insur	rance is offered through SISC:	
Delta Dental Group#: Vision Group		ns Group#: Employee Only
75% premium option list spouse SS#		
A. ENROLLMENT/CHANGE REASON: (see Change	Table for assistance) New gro	up: Yes 🔲 🔲 No
□New Hire (complete sections A, B, C, D) Health Plan (Check one) □HMO Plan □ Deductib	-	nplete sections A, B, C, D)
☐ Loss of Other Coverage (complete sections A, B, C,		
□ Name Change (complete sections A, B, C, D) From:		
Event Date (mm/dd/yyyy)		
B. EMPLOYEE: Have you ever been a Kaiser Permanente	member? Yes	No
Medical Record No. (if known)	Social Security No.	Gender M F
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)	
Home Address	City	State ZIP
Work Phone	Home Phone	Email
Ethnicity	Preferred Language	
C. FAMILY For additional dependents attach a separate	sheet with employee's name at top. (Last, First, MI)
☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner	☐Med ☐Den ☐Vision	Social Security No.
Spouse/domestic partner name:		Birth Date (mm/dd/yyyy)
Gender Male: Female:		Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter	☐ Med ☐Den ☐Vision	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
		Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter	☐ Med ☐Den ☐Vision	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
		Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter	☐ Med ☐ Den ☐ Vision	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
		Medical Record No.
Do any of dependents above live at another address?	☐Yes ☐ No If yes, complete the fo	bllowing:
Name (Last, First, MI):	Address:	
D. Kaiser Foundation Health Plan Arbitration Agreen		The same also recording as the EDICA claims
I understand that (except for Small Claims Court of procedure regulation, and any other claims that can	-	··
myself, my heirs, relatives, or other associated pa		
contracted health care providers, administrators, o		` ,
arising out of or related to membership in KFHP,	·	
services were unnecessary or unauthorized or wer		
relating to the coverage for, or delivery of, services	s or items, irrespective of legal the	eory, must be decided by binding arbitration

Signature required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

arbitration provision is contained in the Evidence of Coverage.

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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

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General instructions

- 1. Please print firmly and legibly in black ink.
- To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
- 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	

^{*}Additional documentation may be required.

