Enrollment 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* _____ Effective date of coverage* ___/___/___

Group number* _____ Enrollment unit/plan* _____

Part I:

❑ New purchaser *(Complete sections A, B, C.)*

❑ Existing policy *(Complete Part II and sections A, B, C.)*

Part II: Enrollment reason* *(Please check one.)*

Date of hire* ___/___/___ DATE

❑ New hire

❑ Part time to full time ___/___/___ DATE

❑ Other _____

❑ Open enrollment

❑ Loss of coverage ___/___/___ DATE

___/___/___ EVENT DATE

To be completed by EMPLOYEE

A Are you now or have you ever been a member of, or received care from, Kaiser Permanente? ❑ Yes ❑ No

If so, what is/was your medical record number *(if known)*? _____ In which state? _____

Name (Last, First, MI)* _____ Former name/Maiden (if any) _____

Home address* _____ Apt. no. _____ City _____ State _____ ZIP _____

Home phone* _____ Work phone _____ Social Security number _____

Date of birth* _____ E-mail _____

Gender* ❑ M ❑ F

Preferred spoken or written language *(optional)* _____ Ethnicity *(optional)* _____

B Family information For additional dependents, attach a separate sheet and please put the employee's name at the top.

❑ Spouse ❑ Domestic partner Name (Last, First, MI): Former last name *(if any)*:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number Medical record number
❑ Child ❑ Student Name (Last, First, MI): Relationship:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number Medical record number
❑ Child ❑ Student Name (Last, First, MI): Relationship:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number Medical record number
❑ Child ❑ Student Name (Last, First, MI): Relationship:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number Medical record number

Do any of your dependents listed above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name (Last, First, MI) _____ Address _____

C **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, 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*.**

X _____ ___/___/___

Employee/Applicant signature* Date*

*Required

KAISER PERMANENTE®

Enrollment Form

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 the "Becoming a member" section of the enrollment booklet.
3. The employer must complete the first section, labeled "To be completed by EMPLOYER."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect your premiums.
5. The employee/subscriber must complete sections A through C.
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 after the effective date.
8. All effective dates and child or student status will be made in accordance with the contractual agreement between the purchaser (your employer) and Kaiser Permanente.

Instructions for completing employer sections and sections A through C:

Employer sections: 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 subscriber, especially effective dates, as they affect premiums.

Section A: The subscriber must complete this section.

Section B: The subscriber 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. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an overage dependent attending school. Please contact your employer regarding the employer's rules for overage dependent students. A completed Student Certification Form may be required.

Section C: The subscriber must read this section, and sign and date at the bottom.