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)
Medical Group Number:	Enrollment Unit:	Effective Enrollment/ Change Date (mm/dd/yyyy)

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#:_____ Vision Group#:_____SISC Life Ins Group#: Employee Only_____

75% premium option list spouse SS#_____

A. ENROLLMENT/CHANGE REASON: (see Change Table for assistance) New group: Yes ☐ ☐ No

☐ New Hire (complete sections A, B, C, D) ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☐ Deductible Plan ☐ Other

☐ Loss of Other Coverage (complete sections A, B, C, D) ☐ Other (please specify) _____

☐ Name Change (complete sections A, B, C, D) From: _____ To: _____

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 Spouse/domestic partner name: Gender Male: ☐ Female: ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

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

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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.

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

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

KAISER PERMANENTE®

California Region Group Enrollment/Change Form

General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. 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.

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