

California Region 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

Company name _____ Hire date (mm/dd/yyyy) _____

Group number _____ Enrollment unit _____ Effective enrollment/change date (mm/dd/yyyy) _____

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 _____ E-mail _____

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 Gender M F Social Security No. _____

Spouse/domestic partner name: _____ Birth Date (mm/dd/yyyy) _____
Former last name (if any): _____ Medical Record No. _____

Add Delete Child Student Gender M F Social Security No. _____

Dependent name: _____ Birth Date (mm/dd/yyyy) _____
Relationship: _____ Medical Record No. _____

Add Delete Child Student Gender M F Social Security No. _____

Dependent name: _____ Birth Date (mm/dd/yyyy) _____
Relationship: _____ Medical Record No. _____

Add Delete Child Student Gender M F Social Security No. _____

Dependent name: _____ Birth Date (mm/dd/yyyy) _____
Relationship: _____ 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, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, 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 (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.

Employee/Applicant signature _____ Date _____ Employer signature _____ Date _____

*Additional documentation may be required.