

# 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

New group account       Existing group account

Company name\* \_\_\_\_\_ Group account number \_\_\_\_\_

Enrollment unit \_\_\_\_\_ Plan description \_\_\_\_\_ Employee classification (if applicable) \_\_\_\_\_

Employee name \_\_\_\_\_ Date of hire \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date coverage to be effective\* \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### \*Enrollment reason (Please check one.)

New group account     New hire     Open enrollment     Part time to full time \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Loss of coverage \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_     Other \_\_\_\_\_    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 in California?       Yes     No

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

Name (Last, First, MI)\* \_\_\_\_\_ Social Security number (optional) \_\_\_\_\_ Preferred spoken or written language (optional) \_\_\_\_\_

Home address\* \_\_\_\_\_ Apt no. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender\*  M  F \_\_\_\_\_

Date of birth\* \_\_\_\_\_ Home phone\* \_\_\_\_\_ Work phone \_\_\_\_\_

## **B** Family Information

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			

Please see next page for additional dependents if needed. Will you be adding additional dependents on page 2?     Yes     No

**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, my relatives, or other associated parties on the one hand and the 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 the 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*.

**X** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Employee/Applicant signature\* (Use black ink only.)      Date\*

(continues)

# Enrollment form (continued)

Employee name \_\_\_\_\_ Company name\* \_\_\_\_\_ Date coverage to be effective\* \_\_\_\_\_

Group number \_\_\_\_\_ Plan selection \_\_\_\_\_

## Family information (additional dependents)

<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			