Oregon group
employee enrollment/change form

KAISER PERMANENTE®

Please print in black or blue ink only. See instructions on the flap before completing this form.

This section to be completed by the employer

Company name* ______________________ Effective date of coverage* ____ / ____ / ____

Group no.* ____________ Medical subgroup no. ____________ billgroup ____ ____ Date of hire ____ / ____ / ____

Dental subgroup no. ____________ billgroup ____ ____

PART I:

☐ New group

☐ Existing group

PART II: Enrollment reason—complete if existing group* *(Please check one.)* Event date ____ / ____ / ____

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part time to full time

☐ Open enrollment ☐ COBRA ☐ State Continuation ☐ Other ____________

A Employee information (Employee complete sections A, B, and C).

Select benefit type: ☐ Medical ____________ (plan choice) ☐ Dental ____________ (plan choice)

Name *(last, first, MI)** ____________ Former name/maiden *(if any)* ____________

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________

Home address* ____________ Apt. ____

City ____________ State ____ ZIP ________ E-mail ____________

Home phone* ____________ Work phone ____________

Health record no. (if any) ____________ Preferred language *(optional)* ____________ Ethnicity *(optional)* ____________

B Dependent information *(For additional dependents, please use our "Additional Dependent" form.)*

☐ Spouse ☐ Domestic partner** Name *(last, first, MI)* ____________ Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ____________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ____________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ____________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

☐ Check here if Additional Dependent form is attached.

C Important

Your application cannot be processed without your signature. Please read the back of this form before signing.

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form.

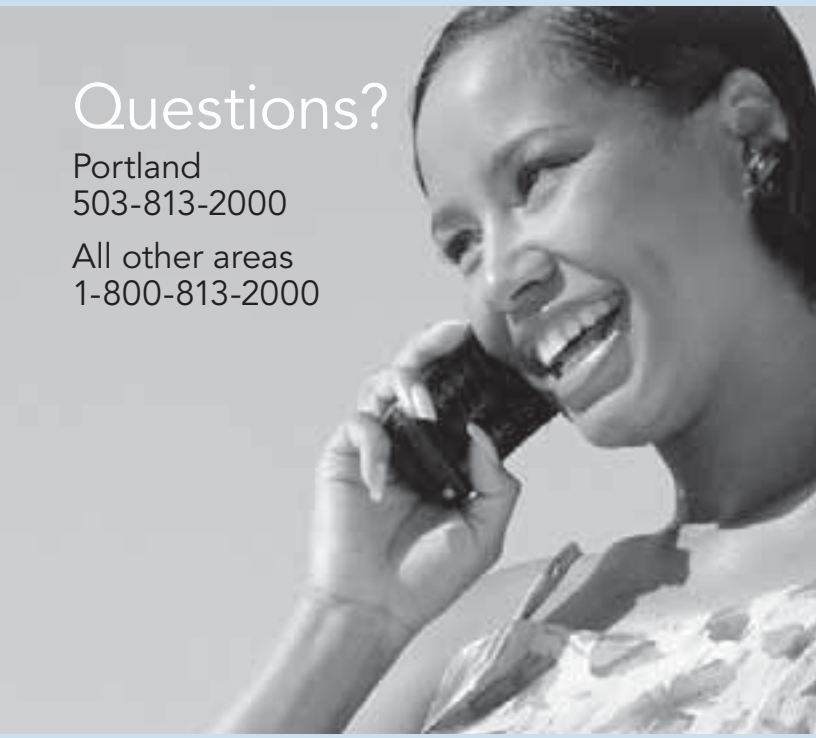
Employee signature* ______________________ Date ____ / ____ / ____

**Required* ***Affidavit required*

How to fill out this form

1. Please print legibly in black or blue ink.
2. To be enrolled, you must live or work within the Northwest service area at least 50% of the time (unless enrolling on an out-of-area plan).
3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting, especially effective dates as these affect your premium.
4. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. The full-time student box should only be marked if your dependent qualifies as an overage dependent attending school. Please contact your employer about its rules for overage dependent students. Read section C and the back of the form. Then sign and date the form.
5. Once the form is complete, make a copy for your records. (You will soon get a membership ID card. Until then, a copy of your enrollment form can be used in the medical offices to identify you as a member.)

All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.



Questions?

Portland
503-813-2000

All other areas
1-800-813-2000

Call Membership Services 8 a.m. to 6 p.m., Monday through Friday. For TTY, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010.

getconnected

Follow the simple steps on the other side to enroll in your plan.

I'm a new member!

Your membership ID card

You will soon be receiving a membership ID card containing your name and unique eight digit health record number. You'll want to have this card handy when you call for an appointment, speak to an advice nurse, or come to us for care. If you don't have your ID card before your first appointment, bring a copy of your enrollment form with you.

Transfer your medical records

Call Membership Services to request a release form (phone number on reverse side). Then send the completed and signed form to your previous health care provider. That provider should send your records to:

Health Information Management
Regional Process Center
10220 SE Sunnyside Road
Clackamas, OR 97015

Transfer your prescriptions

Usually we can arrange a one-time refill of a prescription written by a doctor outside of Kaiser Permanente. Call the main pharmacy number in your medical office at least three days before you need the refill. Certain prescriptions require that you see a Kaiser Permanente provider before we can refill them. Once you have a prescription written by a Kaiser Permanente provider, you have the option of filling it online with postage-paid mail delivery.

KAISER PERMANENTE®

Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow any college, university, or educational institution to furnish KFHPNW with information necessary to establish student eligibility under this plan.
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- I understand that all nonemergency services (including in-network traditional services under the Added Choice and Added Choice Value plans and Added Choice Value) are covered only when provided by or arranged by KFHPNW.

Prior authorization review

If you are enrolling in a Traditional, Deductible or High Deductible medical or dental plan: All services must be authorized or prescribed by Kaiser Permanente providers or Permanente Dental Associates dentists, except for qualifying emergency and urgent care.

If you are enrolling in Added Choice or Added Choice Value: All in-network services must be authorized or prescribed by preferred providers, except for qualifying emergency and urgent care. Most out-of-network nonemergency care and procedures provided in a hospital, another care facility, or your home, except for maternity care, must be authorized at least 72 hours in advance, or your benefit will be reduced.

Temporary enrollment identification: Please make a copy of this form. You will soon receive a membership card. Until then, a copy of your enrollment form can be used in the medical offices to identify you as a member.

If you selected Traditional, Deductible, High Deductible coverage: Present this form to Membership Services located in most Kaiser Permanente facilities to receive services if you have not yet received your membership ID card.

If you selected Added Choice coverage: For in-network services, present this form to Membership Services located in most Kaiser Permanente facilities to receive services if you have not yet received your membership ID card.

For assistance with out-of-network services, call Membership Services at **503-813-2000** in the Portland area or **1-800-813-2000** from all other areas, or **1-800-735-2900** (TTY).

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232