KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

INSTRUCTIONS

Please print neatly.

Be sure to fill in the enrollment form completely. Missing or inaccurate information will delay enrollment processing.

Employer

1. Complete section A on the enrollment forms.
2. Give each enrolling employee an enrollment form to complete.
3. Confirm that the information provided by employees on their enrollment forms is complete and accurate.
4. Return the completed enrollment forms to your broker or Kaiser Permanente.

Employee

1. Complete sections B through D.
2. Sign and date the form.
3. Complete section E only if you need to list additional dependents.
4. Make a copy of the form for your records.

This form serves as your temporary Kaiser Permanente member ID.
Please make a copy and keep it until you receive your official member ID.

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See instructions on page 1 before completing this form. Make a copy for your records.

A TO BE COMPLETED BY EMPLOYER

☐ New group account ☐ Existing account

Company name	Customer ID (if assigned)	Date of coverage to be effective / /
Plan selection	Employee classification (*if applicable*)	
Employee name	Date of hire / /	

Enrollment reason *(Please check one.)* ☐ New group account ☐ New hire ☐ Open enrollment

☐ Part-time to full-time / / ☐ Loss of coverage / / ☐ Other: Event date / /

B TO BE COMPLETED BY EMPLOYEE

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	Preferred language (optional)

Home address (no P.O. boxes)	First day of residency at this address / /	City	State	ZIP

Date of birth / /	Gender ☐ M ☐ F	Home phone ( ) –	Office phone ( ) –

C FAMILY INFORMATION (Please list only those family members to be enrolled.)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

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

Name (Last, First, MI)	Address

Tear along dotted line.

D SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., AND KAISER PERMANENTE INSURANCE COMPANY ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any 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), Kaiser Permanente Insurance Company (KPIC),* 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.

Employee signature X	Date
Employee name (please print)	Title (please print)

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2) the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.*

E FAMILY INFORMATION (additional dependents)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	