ENROLLMENT FORM

Please use black ink. See instructions on page 3 before completing this form. Make a copy for your records.

A To be completed by EMPLOYER

☐ New group account ☐ Existing group account

Company name _____ Group number _____ Date coverage to be effective ____/____/____

Enrollment unit _____ 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 spoken or written language *(optional)* _____

Home address _____ Apt no. _____ City _____ State _____ ZIP code _____

____/____/____ Date of birth Gender ☐ M ☐ F Home phone _____ Work phone _____

C Family information

☐ Spouse ☐ Domestic partner Name (Last, First, MI)	Date of birth	Gender ☐ M ☐ F	Social Security no. Medical record no. *(if known)*
☐ Child Name (Last, First, MI)	Date of birth	Gender ☐ M ☐ F	Social Security no. Medical record no. *(if known)*
☐ Child Name (Last, First, MI)	Date of birth	Gender ☐ M ☐ F	Social Security no. Medical record no. *(if known)*
☐ Child Name (Last, First, MI)	Date of birth	Gender ☐ M ☐ F	Social Security no. Medical record no. *(if known)*

Will you be adding additional dependents? ☐ Yes ☐ No Add any additional dependents on page 2.

D 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 (29 CFR 2560.503-1), certain benefit-related disputes*) 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*.

X _____

Signature required for all Kaiser Permanente plans Date
(Excluding KPIC PPO, KPIC OOA, and KPIC dental plans)

**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) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC dental plans.*

ENROLLMENT FORM

If additional room for dependents is not needed, there is no need to complete or fax this page.

Employee name	Company name	___/___/___ Date coverage to be effective
Group number	Plan selection	

E **Family information** (additional dependents)

☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no.
Name (Last, First, MI)			Medical record no. *(if known)*
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no.
Name (Last, First, MI)			Medical record no. *(if known)*
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no.
Name (Last, First, MI)			Medical record no. *(if known)*
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no.
Name (Last, First, MI)			Medical record no. *(if known)*
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no.
Name (Last, First, MI)			Medical record no. *(if known)*

ENROLLMENT FORM INSTRUCTIONS

Please print neatly and use black ink.

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.