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. _____

Name (Last, First, MI) _____ Birth Date (mm/dd/yyyy) _____ Gender ❑ M ❑ F

Home Address _____ City _____ State _____ ZIP _____

Work Phone _____ Home Phone _____ Email _____

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 Spouse/domestic partner name: Former last name *(if any)*:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) 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. <u>Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement</u>*

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.*

**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.*

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) _____ Date _____

KAISER PERMANENTE®