KAISER PERMANENTE®

Kaiser Permanente Health Plan of the Northwest

Northwest Region Group Enrollment/ Change Form

EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

TO BE COMPLETED BY EMPLOYER **Please print or type in blue or black ink only. Retain last copy for your records and use as a temporary ID after the effective date.**

COMPANY NAME

GROUP NO. SUBGROUP NO. BILLGROUP UNIT DATE OF HIRE (MM/DD/YYYY) EFFECTIVE DATE (MM/DD/YYYY)

NEW ENROLLMENT *Check one:*

- ☐ New group
- ☐ New hire *(complete sections A, B, C, D)*
- ☐ Loss of other coverage *(complete sections A, B, C, D)*
- ☐ Other *(please specify)* _____
- ☐ Cancel all coverage *(empl. and family) (complete section A)*
- ☐ Open enrollment *(complete sections A, B, C, D)*
- ☐ COBRA *(complete sections A, B, C, D)*

Date of event

PLAN *Check one:* ☐ HMO ☐ Added Choice (Point-of-Service) ☐ Out-of-Area ☐ Deductible/Coinsurance ☐ Deductible/Coinsurance w/HSA option

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

DELETE DEPENDENTS (*Complete sections A, B, C, D*)

DATE (MM/DD/YYYY)

- ☐ Divorce
- ☐ Deceased
- ☐ Other *(please specify)*
- ☐ _____

ADD DEPENDENTS (*Complete sections A, B, C, D*)

DATE (MM/DD/YYYY)

- ☐ Birth
- ☐ Adoption*
- ☐ Marriage*
- ☐ Loss of other coverage
- ☐ Other *(please specify)*

OTHER CHANGES (*Complete sections A, B, D*) _____

- ☐ Name change _____
- Previous name _____
- ☐ Address (complete sections A, D)
- ☐ Telephone (complete sections A, D)

*Additional documentation may be required.

0106-0044-02-r04

White copy - Kaiser Permanente **Yellow copy - Employer** **Pink copy - Employee**

A. EMPLOYEE INFORMATION

MEDICAL ☐ DENTAL ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADDRESS

APARTMENT NUMBER | CITY

STATE | ZIP CODE | HOME PHONE | WORK PHONE

What percentage of time do you work in the Kaiser Permanente Northwest service area ☐☐☐ %

PREFERRED SPOKEN OR WRITTEN LANGUAGE (OPTIONAL) | ETHNICITY (OPTIONAL)

B. DEPENDENT INFORMATION

For additional dependents, attach the additonal dependent enrollment form.

[ ] Check here if you've attached an additional sheet.

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ DOMESTIC PARTNER ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____

DISABLED YES ☐ NO ☐ FULL-TIME STUDENT YES ☐ NO ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____

DISABLED YES ☐ NO ☐ FULL-TIME STUDENT YES ☐ NO ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

EMPLOYEE LAST NAME | SOCIAL SECURITY NUMBER

B. DEPENDENT INFORMATION (continued)

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____

DISABLED YES ☐ NO ☐ FULL-TIME STUDENT YES ☐ NO ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____

DISABLED YES ☐ NO ☐ FULL-TIME STUDENT YES ☐ NO ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

Do any of your dependents above live at another address? YES ☐ NO ☐ If yes, please complete the following:

Name(s) (Last, First, MI)	Address

C. BENEFIT COORDINATION/OTHER INSURANCE CARRIER INFORMATION

1. Does anyone listed have other health insurance? YES ☐ NO ☐ If yes, complete the following:

Name _____ Insurance company _____

Policy # _____ Effective date _____ Termination date _____

Other employer name and address _____

2. Is anyone listed permanently disabled? YES ☐ NO ☐ If yes, complete the following:

Name _____ Date disability began _____

3. Is anyone listed eligible for Medicare? YES ☐ NO ☐ If yes, complete the following:

Name _____ Medicare ID # _____

D. 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 reverse sides.

Employee/Applicant signature _____ Date _____ Employer signature _____ Date _____

*Additional documentation may be required.

KAISER PERMANENTE®

Kaiser Permanente Health Plan of the Northwest

Northwest Region Group Enrollment/ Change Form

HOW TO COMPLETE THIS FORM

Please fill in all sections of the form that apply to you. If information we need is missing, your enrollment may be delayed. If you're unclear about any of the information being requested, ask your employer. Please print with a black or blue ballpoint pen and press hard. Give the white and yellow copies of your completed form to your employer. Keep the pink copy for temporary identification in case you need care before you receive your Kaiser Permanente ID card.

TO ENROLL

- Complete all sections of the form except the section titled "To be completed by employer."
- If you're enrolling current or past Kaiser Permanente members, please fill in section B. If they were enrolled under a different name, please provide that name.

TO CHANGE MEMBERSHIP INFORMATION

- If you're adding a dependent because of adoption, fill in the date the child was placed in your home. Attach a copy of the confirmation letter from the adoption agency.
- If you're adding a dependent because of marriage, fill in the date of your marriage.
- If you're adding a dependent because you have court-appointed guardianship, attach a copy of your legal guardianship papers.
- If you're deleting a dependent because of death, fill in the date of death and attach a copy of the death certificate.
- If you're changing your name, fill in the previous and current name(s).

SECTION A—Employee information (Complete all parts of this section if you are enrolling.)

- We need your address to send you important items such as your Kaiser Permanente ID card.
- Stating your ethnicity and language is optional. This information can help Kaiser Permanente meet the health care needs of our members. It will be kept confidential.

SECTION B—Family information (Complete if you are enrolling or deleting eligible dependents.)

- Fill in the requested information for dependents you want to enroll or delete from coverage. If you're only enrolling yourself, don't list any dependents in this section. If you're enrolling more than three dependent children, please attach an additional sheet. For those children, provide the information requested on the form.
- Your plan covers children only up to a certain age, unless a child is disabled or a full-time student at a college, university, or trade school.
- To cover a child who is older than your plan's age limit and is a full-time student, fill in the name and check "yes" for full-time student.
- If you believe any of your children may qualify as a disabled dependent, fill in the name and check "yes" for disabled. In this case, you'll receive additional instructions by mail.

SECTION C—Other coverage information-(Review and complete if applicable.)

- Fill in this section if you or any of your dependents currently have, or previously have had, insurance coverage through any other health plan, including Medicare.

SECTION D—Read the statements following these instructions and sign and date this form. Your signature certifies that you:

- Allow payroll deduction, if any.
- Understand prior authorization review.

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 (Kaiser Permanente) 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 Kaiser Permanente 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 Kaiser Permanente 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 HMO services (including in-network HMO services under the Added Choice plan) are covered only when provided by or arranged by Kaiser Permanente.

PRIOR AUTHORIZATION REVIEW

If you are enrolling in an HMO medical or dental plan: All services must be authorized or prescribed by Kaiser Permanente physicians or dentists, except for qualifying emergency and urgent care.

If you are enrolling in Point-of-Service: All in-network services must be authorized or prescribed by Kaiser Permanente physicians or dentists, 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.

If you are declining coverage: I understand I will not be eligible to enroll myself or my dependents until the next open enrollment, unless I meet the requirements for a special enrollment.

Temporary enrollment identification: Keep the pink copy of this form to show as temporary identification in case you need care before you receive your Kaiser Permanente ID card.

If you selected HMO coverage: Present this form to Membership Services located in most Kaiser Permanente facilities.

If you selected Point-of-Service coverage: For in-network HMO services, present this form to Membership Services located in most Kaiser Permanente facilities.

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).