

Please print or type in black ink only. Please see instructions on reverse *before* completing this form.  
Fields with \* are mandatory for enrollment.

**A. TO BE COMPLETED BY EMPLOYER**

\*Company or Trust Fund Name \_\_\_\_\_ \*Purchaser Number \_\_\_\_\_ Enrollment Unit Number (EU) \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Company or Trust Fund Address \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Purchaser Contact \_\_\_\_\_ Employer ID \_\_\_\_\_ \*Effective Date of Coverage \_\_\_\_\_

**\*ENROLLMENT (check only one—see Enrollment Reason Table on reverse side for options)**

New Hire Enrollment—Date of Hire: \_\_\_\_\_  Open Enrollment  
 Part Time to Full Time—Date: \_\_\_\_\_  Other: \_\_\_\_\_ Event Date: \_\_\_\_\_  
 New Purchaser

**B. EMPLOYEE/SUBSCRIBER INFORMATION**

Are you now or have you ever been a Kaiser Permanente member?  Yes  No Height \_\_\_\_\_  
 If so, what is/was your Medical Record Number? \_\_\_\_\_ Weight \_\_\_\_\_  
 Have you ever received care from Kaiser Permanente within the state of California?  Yes  No  
 Under what name: \_\_\_\_\_  
 \_\_\_\_\_ Maiden/Other \_\_\_\_\_

\*Social Security Number \_\_\_\_\_ \*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_ MI \_\_\_\_\_  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \*Gender:  M  F Marital Status:  Married  Single  
 \*Date of Birth \_\_\_\_\_

Preferred Language Spoken \_\_\_\_\_ Preferred Language Written \_\_\_\_\_ E-mail Address (optional) \_\_\_\_\_

\*Street Address \_\_\_\_\_ \*City \_\_\_\_\_ \*State \_\_\_\_\_ \*ZIP Code \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Employment Status:  
 Day Phone  Home  Work Evening Phone  Home  Work Employee ID \_\_\_\_\_  Working  Retired

**C. LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed)**

*Last Name	*First Name	MI	*Role	*Social Security Number	*Date of Birth MM/DD/YY	*Gender	Medical Record Number if Known	Height	Weight
<b>Spouse</b>			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Maiden/Other: _____									
<b>Dependent</b>			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Relationship: _____									
<b>Dependent</b>			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Relationship: _____									
<b>Dependent</b>			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Relationship: _____									
<b>Dependent</b>			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Relationship: _____									

**Dependent(s)' Address (if different from subscriber's):**  Check here if all dependents are at the address below.

Name(s)	Address	City	State	ZIP Code
---------	---------	------	-------	----------

**Kaiser Foundation Health Plan Arbitration Agreement:**  
 I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the *Evidence of Coverage*.

# Enrollment Application Instructions

## Instructions for the Subscriber:

1. Review the **Kaiser Permanente ZIP Code Service Areas** on page 3 to make sure your home ZIP code is listed.
2. Check the box for your group's plan on the cover of this booklet and on your Temporary Membership ID, located on page 5.
3. Complete **Section B** of this *Enrollment Application*. Be sure to complete all fields to ensure we have your current information and can find any prior membership records. Please print clearly in black ink.
4. Complete **Section C** of this *Enrollment Application* for any dependents you wish to enroll. Kaiser Permanente will verify the eligibility of these dependents during the enrollment process.
5. Check with your employer to see if you are required to complete the Health Questionnaire in **Section D** of this *Enrollment Application* (required for groups with 6 – 15 enrolling employees only). If you are required to complete Section D, please follow the instructions at the top of page A-2.
6. Sign and date the bottom of page A-1 (and page A-3, if applicable).
7. Keep a copy of page A-1 of this *Enrollment Application*, to be used with your Temporary Membership ID when seeking health care services.

## Instructions for the Employer:

1. Complete all fields in **Section A** to ensure we have correct account and enrollment reason information. Always indicate the appropriate enrollment reason. For "other" enrollment requests, write in the reason from the table below. Be sure to include the event date, where requested.

**If this enrollment is part of your new group set-up with Kaiser Permanente, check "New Purchaser."**

### Enrollment Reason Table

Enrollment Reason	Event Date
Part-Time to Full-Time Status	Effective Date of Full-Time Status
Loss of Coverage	Date Coverage Was Lost
Moved into Service Area	Move Date
Rehire	Date of Rehire
Return from Layoff/Leave of Absence	Return Date
Return from Military Duty	Return Date

2. The employer is responsible for confirming all information on page A-1 of this *Enrollment Application* prior to submission. Provide each employee with a copy of page A-1, to be used with their Temporary Membership ID.
3. For groups with 6 – 15 enrolling employees only: The employees who enroll as part of your new group set-up are required to complete the Health Questionnaire in **Section D**, which will be used to determine your group's rate. To protect the privacy of your employee, this application must remain sealed and can only be opened by an authorized Kaiser Permanente representative.

NOTE: All enrollments will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.