

Enrollment Application/Change Form

Please print or type in black or dark blue ink. Please see instructions on reverse before completing this form.

Retain last copy for your records and use as a temporary ID.

To Be Completed by Employer

Purchaser Number _____ Enrollment Unit Number (EU) _____

Effective Date: ____/____/____

A. ENROLLMENT REASON (check one) <input type="checkbox"/> New Hire Enrollment <input type="checkbox"/> New Purchaser <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Enrollment Unit <input type="checkbox"/> Other _____ <small>(Enter reason from back of form)</small> Event Date: ____/____/____	B. CHANGE REASON (check all that apply) <input type="checkbox"/> Add/Delete Dependent(s) _____ <small>(Enter reason from back of form)</small> <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change (see below) <input type="checkbox"/> Other _____ <small>(Enter reason from back of form)</small> Event Date: ____/____/____
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C. ABOUT YOU (Subscriber)

Last Name	First Name	MI	Are you now or have you ever been a Kaiser Permanente member? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you have ever been a Kaiser Permanente member, what is/was your Medical Record Number (from your ID card)?	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth
Street Address <input type="checkbox"/> Check here if new address and complete Section G below.	City	State	Zip Code
		Home Phone <input type="checkbox"/> Day <input type="checkbox"/> Eve	Work Phone <input type="checkbox"/> Day <input type="checkbox"/> Eve

D. IF THIS IS AN ENROLLMENT, WE'D LIKE TO KNOW A LITTLE BIT MORE ABOUT YOU

Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Maiden Name (if applicable)	Language Spoken	Language Written
Have you ever received care from Kaiser Permanente within the state of California? <input type="checkbox"/> Yes <input type="checkbox"/> No			

E. ABOUT YOUR EMPLOYMENT

Company Name	City	Employee ID	Employment Status <input type="checkbox"/> Working <input type="checkbox"/> Retired
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F. NAME CHANGE

From	to	To
Last Name	First Name	Last Name First Name

G. ADDRESS CHANGE (What was your previous address?)

Street Address	City	State	Zip Code
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H. ABOUT YOUR FAMILY Previous Kaiser Foundation Health Plan members should list their Medical Record Numbers (if known)

Last Name	First Name	MI	Role	Social Security Number	Date of Birth mm/dd/yy	Sex M/F	Add/Delete	Medical Record Number if Known
Spouse			<input type="checkbox"/> Spouse	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
Maiden Name (if applicable)								
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete	

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

Name(s)	Address	City	State	Zip Code
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I understand that, except for small claims court cases and claims subject to the Medicare Appeals Procedure, any claim that I, my heirs, or other claimants associated with me assert for alleged violation of any duty arising out of or relating 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 a lawsuit or resort to court process except as California 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 complete arbitration provision is contained in the Evidence of Coverage.

Subscriber's Signature: _____ Date: ____/____/____