ENROLLMENT FORM INSTRUCTIONS

Please print neatly.

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.

This form serves as your temporary Kaiser Permanente member ID.
Please make a copy and keep it until you receive your official member ID.

ENROLLMENT FORM

See instructions on page 1 before completing this form. Make a copy for your records.

A To be completed by EMPLOYER

☐ New group account ☐ Existing group account

Company name _____ Customer ID _____ Date coverage to be effective ____/____/____

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 (Please list only those family members to be enrolled)

☐ Spouse ☐ Domestic partner	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)*

Will you be adding additional dependents? ☐ Yes ☐ No Add any additional dependents on page 3.

D AGREEMENT TO THE USE OF BINDING ARBITRATION FOR MEMBER DISPUTES*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and claims that cannot be subject to binding arbitration under governing law), disputes between KFHP members or KPIC enrollees,* their heirs, relatives, or associated parties (on the one hand) and KFHP, KPIC, Kaiser Permanente health care providers, or other associated parties (on the other hand), for alleged violation of any duty arising out of or related to KFHP membership or KPIC coverage, including any claim for medical or hospital malpractice (a claim that medical services or items 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. KFHP members and KPIC enrollees thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* or *Certificate of Insurance*.

X _____

Signature required for all Kaiser Permanente plans Date

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 and 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

Customer ID ______________________ 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)* ______

Tear along dotted line.