

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

Retain last copy for your records and use as a temporary ID, after the effective date.

A. TO BE COMPLETED BY EMPLOYER

Company Name or Trust Fund Name	Purchaser Number	Enrollment Unit Number (EU)
Purchaser Contact	Phone Number	Fax Number

B. REQUESTED CHANGE(S) (See reverse for instructions)

- | | |
|--|---|
| <input type="checkbox"/> Address Change (Complete Section C) | <input type="checkbox"/> Add Dependent (Complete Sections C and E) |
| <input type="checkbox"/> Name Change (Complete Sections C and D) | <input type="checkbox"/> Delete Dependent (Complete Sections C and E) |

C. EMPLOYEE/SUBSCRIBER INFORMATION (Please complete all fields)
 Check here if new address

Last Name	First Name	MI	Date of Birth	Medical Record Number
Street Address		City	State	ZIP Code
Social Security Number	Day Phone	Evening Phone		

D. NAME CHANGE

From: Last Name First Name MI	To: Last Name First Name MI
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E. LIST FAMILY MEMBERS TO BE ENROLLED/DELETED (Please attach additional sheet, if adding more than three dependents.)

Have any dependents ever been Kaiser Permanente members? If so, please indicate their Medical Record Number in the field below.

Spouse	<input type="checkbox"/> Add	<input type="checkbox"/> Delete			
Last Name	First Name	MI	Medical Record No.	Social Security No.	Maiden/Other Name
Reason for Add/Delete (See back of form)			Date of Birth	Event Date	Effective Date

Dependent 1	<input type="checkbox"/> Add	<input type="checkbox"/> Delete			
Last Name	First Name	MI	Medical Record No.	Social Security No.	Relationship
Reason for Add/Delete (See back of form)			Date of Birth	Event Date	Effective Date

Dependent 2	<input type="checkbox"/> Add	<input type="checkbox"/> Delete			
Last Name	First Name	MI	Medical Record No.	Social Security No.	Relationship
Reason for Add/Delete (See back of form)			Date of Birth	Event Date	Effective Date

Dependent 3	<input type="checkbox"/> Add	<input type="checkbox"/> Delete			
Last Name	First Name	MI	Medical Record No.	Social Security No.	Relationship
Reason for Add/Delete (See back of form)			Date of Birth	Event Date	Effective Date

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
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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 mal-practice, 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*.

X
Subscriber Signature (Required for all changes)

X
Date

Account Change Form Instructions

General instructions:

1. Please print firmly and legibly in black ink.
2. To be enrolled, you must reside within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete Section A.
4. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections B through E. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including Section A), the subscriber should retain the last copy for their records to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing Sections A through E:

Section A: The employer must complete all fields to ensure we have correct account and enrollment reason information. **The employer is responsible for confirming all information submitted by the subscriber, especially effective dates as they affect the Health Plan dues.**

Section B: The subscriber must indicate the requested change they are making to their account. They must then complete the other sections indicated. Please print legibly in black ink.

Section C: The subscriber must always complete this section, even when making minor changes to the account. This ensures our information is current. Please mark the box if your address is new. Always include your Medical Record Number.

Section D: The subscriber should complete this section to notify Kaiser Permanente of a name change. Include both the prior name and the new name.

Section E: The subscriber should complete this section when adding, updating, or deleting dependent information. Include any prior last names for both spouse and dependents. Include their Kaiser Permanente Medical Record Number, if they have one. Include the reason and event date for the dependent addition or deletion from the table below.

Addition/Deletion Reasons and Event Dates

Add Dependent Reason	Event Date
Acquired Student Status	Date Student Status Was Obtained
Family Adoption	Date of Adoption
Loss of Coverage	Date Coverage Was Lost
New Spouse	Date of Marriage
Moved into Service Area	Move Date
Newborn Addition	Date of Birth
Open Enrollment	Open Enrollment Effective Date

Delete Dependent Reason	Event Date
Loss of Student Status	Date of Status Change
Divorce	Date of Divorce
Member Deceased	Date of Death
Delete Dependent(s)	Dependent Termination Date
Open Enrollment	Open Enrollment Effective Date