Enrollment form

Please print or type in black ink only. See instructions on page 17 before completing this form. Make a copy for your records.

To be completed by EMPLOYER ❑ New group account ❑ Existing group account

Company name* _____ Group account number _____

Enrollment unit _____ Plan description _____ Employee classification (if applicable) _____

Employee name _____ Date of hire ____/____/____ Date coverage to be effective* ____/____/____

***Enrollment reason** (*Please check one.*)

❑ New group account ❑ New hire ❑ Open enrollment ❑ Part time to full time ____/____/____

❑ Loss of coverage ____/____/____ ❑ Other _____ Event date ____/____/____

To be completed by EMPLOYEE

A Are you now or 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 *(optional)* _____ Preferred spoken or written language *(optional)* _____

Home address* _____ Apt no. _____ City _____ State _____ ZIP _____

____/____/____ Date of birth* Gender* ❑ M ❑ F Home phone* _____ Work phone _____

B Family Information

❑ Spouse ❑ Domestic partner Name (Last, First, MI) _____	Date of birth	Gender* ❑ M ❑ F	Social Security no. or medical record no.
❑ Child ❑ Student Name (Last, First, MI) _____	Date of birth	Gender* ❑ M ❑ F	Social Security no. or medical record no.
❑ Child ❑ Student Name (Last, First, MI) _____	Date of birth	Gender* ❑ M ❑ F	Social Security no. or medical record no.
❑ Child ❑ Student Name (Last, First, MI) _____	Date of birth	Gender* ❑ M ❑ F	Social Security no. or medical record no.

Please see next page for additional dependents if needed. Will you be adding additional dependents on page 15? ❑ Yes ❑ No

C Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for small claims court cases, claims subject to a Medicare appeals procedure, and, if my group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, my relatives, 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 (a claim that medical services 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. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

(continues)

X _____

Employee/Applicant signature* **(Use black ink only.)** Date*