



Please print or type in black ink only. See instructions on reverse before completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER

Company name _____

Date of hire _____

Group number _____

Enrollment unit _____

Effective date of enrollment or coverage _____

NEW ENROLLMENT Check one:

New purchaser

Open enrollment (complete sections A, B, C, D)

New hire (complete sections A, B, C, D)

Other (please specify) _____

Loss of other coverage (complete sections A, B, C, D)

Date of event _____

PLAN Check one: HMO Deductible Plan

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

Add dependents (complete sections A, B, D) Delete dependents (complete sections A, B, D)

*Reason: _____ (see Change Reason Table) Event date: _____

Name change (complete sections A, B, D) From: _____ To: _____

Address (complete section A) _____

Telephone (complete section A): _____

A. EMPLOYEE INFORMATION

Name (Last, First, MI) _____ Former last name (if any) _____

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

Home phone _____ Work phone _____ Medical Record no. (if known) _____

M F

Gender: E-mail _____ Social Security no. _____

Date of birth _____ Preferred spoken or written language (optional) _____ Ethnicity (optional) _____

B. FAMILY INFORMATION For additional dependents, attach a separate sheet and please put the employee's name at the top. (Last, First, MI)

Add Delete Spouse Domestic partner Gender M F Social Security number _____

Spouse/Domestic partner name: _____ Date of birth _____ Medical Record number _____

Former last name (if any): _____ Gender M F Social Security number _____

Add Delete Child Student Date of birth _____ Medical Record number _____

Dependent name: _____ Gender M F Social Security number _____

Relationship: _____ Date of birth _____ Medical Record number _____

Add Delete Child Student Gender M F Social Security number _____

Dependent name: _____ Date of birth _____ Medical Record number _____

Relationship: _____ Date of birth _____ Medical Record number _____

Do any of your dependents above live at another address? Yes No If yes, complete the following:
Name(s) (Last, First, MI): _____ Address: _____

C. OTHER COVERAGE INFORMATION:

Including yourself, do any of the persons listed above have other coverage? Yes No

Name _____ Insurance carrier name _____ Policy no./Effective date _____ Phone no. _____

D. 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 Employee Retirement Income Security Act 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 full Arbitration provision is contained in the Evidence of Coverage.

Employee/Applicant signature _____ Date _____ Employer signature _____ Date _____