KAISER PERMANENTE®

Small Business

EMPLOYEE ENROLLMENT

IMPORTANT INFORMATION

Use this form to enroll in Kaiser Permanente. If you're already an existing member, please use the **Employee Dependent Change** form.
Please print neatly.

Be sure to fill in the form completely. Missing or inaccurate information will delay enrollment processing.

Existing groups: For questions, please call **800-790-4661, option 1.** Email completed form to **csc-sd-sba@kp.org** as a PDF attachment or fax to **855-355-5334.**

Employer

1. Complete section 1.

   If enrollment reason is *loss of coverage* or *other*, the event must be one of the special enrollment qualifying events listed below:

   - New hire
   - Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility.
   - Return from a leave of absence
   - Involuntary termination or loss of other group coverage
   - A dependent loses coverage elsewhere (if the employee is already enrolled, please use the **Employee Dependent Change Form** to add your dependents)
   - Marriage or addition of a domestic partner
   - Birth, adoption of a child or placement for adoption
   - Court order
   - Death of a spouse, domestic partner, or dependent
2. Give each employee a form to complete.
3. Confirm that the information provided on the form is complete and accurate.
4. Return the completed enrollment forms to your broker or Kaiser Permanente.

Employee

1. Complete sections 2 through 4.
2. Sign and date the form.
3. Make a copy of the form for your records.

If you're a new member, this form serves as your temporary Kaiser Permanente member ID. Please make a copy and keep it until you receive your official member ID. If you're a member transferring from another Kaiser Permanente Health Plan (within the same region) keep your existing membership card, as your medical record number remains unchanged.

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

1 TO BE COMPLETED BY EMPLOYER

Company name*	Group ID (if assigned)	Effective date* (can only start the first of the month) / 01 /

Plan selection/Subgroup ID (if assigned)*	Employee classification (if applicable)

Enrollment reason (Please check one) ☐ New group account ☐ Open enrollment ☐ Other:

If you have an **existing** account, please email completed form to **csc-sd-sba@kp.org** as a PDF attachment or fax to **855-355-5334.**

2 TO BE COMPLETED BY EMPLOYEE (All fields with * are required.)

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

Social Security number*	Former/Maiden name		
Last name*	First name*	MI	Preferred language (optional)

Home address*	Apt. #

City*	State*	ZIP*	County

Mailing address (if different from home)	Apt. #

City	State	ZIP	County

Date of birth (mm/dd/yyyy)*	Gender*	Day phone	Evening phone
/ /	☐ M ☐ F ☐ Undeclared	( ) –	( ) –

If you decline coverage for yourself or an eligible dependent, you can only enroll during an annual open enrollment period established by your employer, or during a special enrollment period if you've experienced a qualifying event. You must request coverage within 60 days of a qualifying event. Special enrollment qualifying events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court order that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that's serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that's been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual didn't enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*(All fields with * are required.)*

3 FAMILY INFORMATION (Please list only those family members to be enrolled.)

Check one ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)*			
Former name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			

If any dependent listed above lives at another address, complete the following:

Name (Last, First, MI)	Address
Name (Last, First, MI)	Address

4 READ AND SIGN

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT†

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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*.

Employee name (please print)*

Employee signature*	Date
X	

(All fields with * are required.)

†Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage aren't subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.

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