

# Enrollment application

## *Change of information/waiver form*

### **Questions?**

Ask your employer or call Kaiser Permanente Membership Services,  
Monday through Friday, 8 a.m. to 6 p.m., except holidays.

**Portland area** ..... 503-813-2000

**All other areas** ..... 1-800-813-2000

**TTY** ..... 1-800-735-2900

**Language interpretation services** ..... 1-800-324-8010

# How to complete this form

Please fill in all sections of the form that apply to you. If information we need is missing, your enrollment may be delayed. If you're unclear about any of the information being requested, ask your employer. Please print with a ballpoint pen and press hard.

## To enroll

- Complete all sections of the form, except Section 2.
- If you're enrolling current or past Kaiser Permanente members, please fill in Section 5. If they were enrolled under a different name, please provide that name.

## To Change membership information

- Fill in the employee's name.
- If you checked address change in Section 2, fill in your new address in Section 3. If you checked name change, fill in the new and former name(s) in Section 3 and/or 4.

## Section 1 – Enrollment information (Complete both parts of this Section)

If you're a new employee, please provide your hire date, the effective date of your benefits, and the percentage of time you work in the Kaiser Permanente Northwest service area.

## Section 2 – Membership change information (Complete this section if it applies)

If you're adding a dependent because of adoption, fill in the date the child was placed in your home. Attach a copy of the confirmation letter from the adoption agency. If you're adding a dependent because you have court-appointed guardianship, attach a copy of your legal guardianship papers.

## Section 3 – Employee information (Complete all parts of this section if you are enrolling)

Select the coverage you want. For medical coverage choose between HMO and Added Choice (Point-of-Service plan)

Group/employer name is usually the same as your current employer.

We need your address to send you important items such as your Kaiser Permanente ID Card

Stating your ethnicity and language is optional. This information can help Kaiser Permanente meet the health care needs of our members. It will be kept confidential.

## Section 4 – Dependent information (Complete if you are enrolling or deleting eligible dependents, or waiving coverage)

Fill in the requested information for dependents you want to enroll or delete from coverage. If you're enrolling yourself only, don't list any dependents in this section. If you're enrolling more than three dependent children, please attach an additional sheet. For those children, provide the information requested on the form. Stating ethnicity is optional. This information can help Kaiser Permanente meet the health care needs of our members. It will be kept confidential.

Your plan covers children only up to a certain age, unless a child is disabled or a full-time student at a college, university, or trade school.

- o To cover a child who is older than your plan's age limit and a full-time student, fill in the child's name and check "yes" for full-time student. Also fill in the name of the school.

- o If you believe any of your children may qualify as a disabled dependent, fill in the name and check "yes" for disabled. In this case, you'll receive additional instructions by mail.

If you waive coverage, you won't be able to enroll until the next open enrollment, unless you qualify for special enrollment.

## Section 5 – Other important information (Review and complete if applicable)

Fill in this section if you or any of your dependents currently have, or previously have had, Kaiser Permanente coverage in this region.

**Your signature – Always sign and date this form after reading the back. Your signature certifies that you:**

Allow payroll deductions, if any.

Understand prior authorization review (see the back of the enrollment form).

**Give the white and pink copies of your completed form to your employer.**

**Keep the yellow copy for temporary identification if you need care before you receive your Kaiser Permanente ID card.**



# Enrollment application/Change of information form

Keep the yellow copy for identification until your Kaiser Permanente identification card arrives. **Print** with a ballpoint pen and press hard. Please write legibly.

What percentage of time do you work in the Kaiser Permanente Northwest service area? \_\_\_\_\_ %

1. Enrollment information—Complete both parts of this section. Check the appropriate box:

New hire application Date of hire \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Effective date of benefits \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Open enrollment application Reason \_\_\_\_\_

2. Membership change information—Check all categories that apply and fill in dates where requested.

Change of address—fill in your name and new address in section 3.  Name change—provide former and new name(s) in section 3 and/or section 4.

Adding dependents. List name(s) and birth date(s) of dependents you are adding in section 4. Check reason and provide date:

Newborn \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Adoption \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Marriage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Loss of coverage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Deleting dependents. List name(s) and birth date(s) of dependents you are deleting in section 4. Check reason and provide date:

Divorce \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Over age limit \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Death \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Other (explain) \_\_\_\_\_

3. Employee information—For enrollment, complete this section.

Check medical plan <input type="checkbox"/> HMO <input type="checkbox"/> Added Choice® (point-of-service plan)	Group/employer name	Employee number	Status (check one) <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	Date of birth	Social Security number
	Last name	First name	M.I.	Former name, if changing	Sex (M/F)
Street address	Apt.	City	State	ZIP	Home telephone (with area code)
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multi-ethnic <input type="checkbox"/> Native Hawaiian or Pacific Islander					Work telephone (with area code)

Optional: How would you describe yourself?  White  Other (please specify) \_\_\_\_\_

Optional: Do you or an enrolled dependent need an interpreter? If so, specify who \_\_\_\_\_  
Which language?  Cambodian  Cantonese  Romanian  Russian  Spanish  Vietnamese  Other (please specify) \_\_\_\_\_

4. Member information—Complete this section if you want to enroll, delete, or waive coverage for eligible dependents, or waive coverage for yourself.

Check coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Self	Date of birth	Sex (M/F)	Social Security number	If you currently have other group coverage (for exceptions see underwriting guidelines)		Optional: Ethnic background (if different from employee)
					Waive* <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy number or Medicare claim number	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Spouse				Group contract number	Employer	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Child						
<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Child						
<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Child						

I understand that I will not be able to enroll myself or my dependents until the next open enrollment, unless I qualify for a special enrollment. any of your dependent children are over the maximum age and disabled or a full-time student at a college, university, or trade school, list below.

Name	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school, university, or trade school
Name	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school, university, or trade school

5. Other important information—Complete this section if it applies to you or your dependents.

I or my dependents currently have, or previously have had, Kaiser Permanente coverage in this region.

Name \_\_\_\_\_ Former name, if different \_\_\_\_\_ Health record number \_\_\_\_\_  
Name \_\_\_\_\_ Former name, if different \_\_\_\_\_ Health record number \_\_\_\_\_

Important: Your application cannot be processed without your signature. Please read the back of this form before signing. I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the reverse side.

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_  
White copy—Kaiser Permanente Yellow copy—employee Pink copy—employer

# Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

## All employees completing this form:

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (Kaiser Permanente) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that Kaiser Permanente or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not a HIPAA authorization.
- I allow any college, university, or educational institution to furnish Kaiser Permanente with information necessary to establish student eligibility under this plan.
- I allow the proper deductions, if any, to be made from my earnings as part of the cost of this coverage.
- I understand that all non-emergency HMO services (including in-network services under the Added Choice plan) are covered only when provided by or arranged by Kaiser Permanente.

## Prior authorization review:

### If you are enrolling in an HMO medical or dental plan –

All services must be authorized or prescribed by Kaiser Permanente physicians or dentists, except for qualifying emergency and urgent care.

### If you are enrolling in Added Choice –

All in-network services must be authorized or prescribed by Kaiser Permanente physicians or dentists, except for qualifying emergency and urgent care. Most out-of-network non-emergency care and procedures provided in a hospital, another care facility, or your home, except for maternity care, must be authorized at least 72 hours in advance, or your benefit will be reduced.

### If you are declining coverage –

I understand I will not be eligible to enroll myself or my dependents until the next open enrollment, unless I meet the requirements for a special enrollment.

## When you need care: temporary enrollment identification

Keep the **yellow** copy of this form to show as temporary identification if you need care before you receive your plastic Kaiser Permanente ID Card.

If you select HMO coverage: Present this form to Membership Services located in most Kaiser Permanente facilities.

If you select Added Choice coverage: For in-network (HMO) services, present this form to Membership Services located in most Kaiser Permanente facilities.  
For assistance with out-of-network services, call Membership Services at 503-813-2000 in the Portland area or 1-800-813-2000 from all other areas.