



# CHANGE OF ACCOUNT STATUS REQUEST

Group no. \_\_\_\_\_ Subgroup no. \_\_\_\_\_ Account no. \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Social Security no. \_\_\_\_\_

Employee/company name \_\_\_\_\_ Employee no. \_\_\_\_\_

**ACTION REQUESTED:**

Add/delete dependents listed on reverse

Address change

New street address \_\_\_\_\_ Apt. no. \_\_\_\_\_

City, state, zip \_\_\_\_\_

Change my name to that shown above. My former name was \_\_\_\_\_

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We understand that, except for small claims court cases, any claim that we, our heirs, or other claimants associated with us assert for alleged violation of any duty arising out of or relating to the Service Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, service pursuant to the Agreement, irrespective of legal theory, must be decided by binding arbitration under California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. We are therefore giving up our right to a jury trial and are accepting the use of binding arbitration.

Subscriber's signature X \_\_\_\_\_ Date \_\_\_\_\_ Telephone no. \_\_\_\_\_

98555(REV. 2-95)

Check One		Check One		List Dependents Below (please print)	Marriage Date			Birth Date			If dependent is, or was a member, give medical record number, and/or maiden or former name.
Add	Delete	Husband	Wife*		MO.	DAY	YEAR	MO.	DAY	YEAR	
		<input type="checkbox"/>	<input type="checkbox"/>	LAST NAME: _____ FIRST _____ M.I. _____							
		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								
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		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								
		<input type="checkbox"/>	<input type="checkbox"/>								

Instructions: Please complete and sign both sides of this form and return it to your employer or benefits administrator. Do not send this form to Kaiser Permanente unless otherwise instructed by your benefits representative.