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Enrollment Application/Change Form

Please print or type in black or dark blue ink. Please see instructions on reverse before completing this form.
Retain last copy for your records and use as a temporary ID.

To Be Completed by Employer

___ ___ ___ ___ ___ ___ - ___ ___ ___ ___
Purchaser Number — Enrollment Unit Number (EU)

Effective Date: ____/____/____

A. ENROLLMENT REASON (check one)

❑ New Hire Enrollment ❑ New Purchaser
❑ Open Enrollment ❑ New Enrollment Unit
❑ Other ____________ (Enter reason from back of form)

Event Date: ____/____/____

B. CHANGE REASON (check all that apply)

❑ Add/Delete Dependent(s) ____________ (Enter reason from back of form)
❑ Address Change ❑ Name Change (see below)
❑ Other ____________ (Enter reason from back of form)

Event Date: ____/____/____

C. ABOUT YOU (Subscriber)

Last Name	First Name	MI	Are you now or have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

If you have ever been a Kaiser Permanente member, what is/was your Medical Record Number (from your ID card)?	Gender ❑ M ❑ F	Social Security Number — —	Date of Birth / /

Street Address ❑ Check here if new address and complete Section G below.	City	State	Zip Code	Home Phone ❑ Day ❑ Eve ( )	Work Phone ❑ Day ❑ Eve ( )

D. IF THIS IS AN ENROLLMENT, WE'D LIKE TO KNOW A LITTLE BIT MORE ABOUT YOU

Marital Status ❑ Married ❑ Single	Maiden Name (if applicable)	Language Spoken	Language Written

Have you ever received care from Kaiser Permanente within the state of California? ❑ Yes ❑ No

E. ABOUT YOUR EMPLOYMENT

Company Name	City	Employee ID	Employment Status ❑ Working ❑ Retired

F. NAME CHANGE

From ________ (Last Name) ________ (First Name) to ________ (Last Name) ________ (First Name)

G. ADDRESS CHANGE (What was your previous address?)

Street Address	City	State	Zip Code

H. ABOUT YOUR FAMILY Previous Kaiser Foundation Health Plan members should list their Medical Record Numbers (if known)

Last Name	First Name	MI	Role	Social Security Number	Date of Birth mm/dd/yy	Sex M/F	Add/ Delete	Medical Record Number if Known
Spouse *Maiden Name (if applicable)*			❑ Spouse	— —	/ /	❑ M ❑ F	❑ Add ❑ Delete	
Dependent			❑ Child ❑ Student ❑ Other	— —	/ /	❑ M ❑ F	❑ Add ❑ Delete	
Dependent			❑ Child ❑ Student ❑ Other	— —	/ /	❑ M ❑ F	❑ Add ❑ Delete	
Dependent			❑ Child ❑ Student ❑ Other	— —	/ /	❑ M ❑ F	❑ Add ❑ Delete	
Dependent			❑ Child ❑ Student ❑ Other	— —	/ /	❑ M ❑ F	❑ Add ❑ Delete	

Dependent's Address (if different from subscriber): ❑ Check here if all dependents are at the address below.

Name(s)	Address	City	State	Zip Code

I understand that, except for small claims court cases and claims subject to the Medicare Appeals Procedure, any claim that I, my heirs, or other claimants associated with me assert for alleged violation of any duty arising out of or relating 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 a lawsuit or resort to court process except as California 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 complete arbitration provision is contained in the *Evidence of Coverage*.

Subscriber's Signature: ____________ Date: ____/____/____

TOP COPY–To CSC (California Service Center) **MIDDLE COPY**–To be retained by purchaser **BOTTOM COPY–To be retained by subscriber and used as temporary ID**

![KAISER PERMANENTE®]

KAISER PERMANENTE®

DOWNLOADED FROM PURCHASER INTRANET SITE

Enrollment Application/Change Form

Completing your Enrollment Application/Change Form

1. Please print firmly and legibly.
2. You must reside within the zip codes listed below.
3. Complete Sections A through H. See below for detailed instructions.
4. Be sure to include your signature at the bottom of the form.
5. After your employer has completed the Purchaser Number, Enrollment Unit Number, and Effective Date, **retain the last copy for your records and use it as a temporary ID.**

Instructions for Sections A through H:

A. For enrollments or additions, please indicate the Enrollment Reason and Event Date.[1]
B. For changes to an existing account, indicate the type of change or reason and Event Date.[1]
C. Fill in complete information about the subscriber on the account.
D. Complete this section for new enrollment.
E. Fill in complete information about your employment.
F. Please complete this section for Name Changes only.
G. Complete for Address Change.
H. This section must be completed when adding, deleting, or changing information about your dependents.

Please consult *The Guidebook to Kaiser Permanente Services* or your *Disclosure Form* and *Evidence of Coverage* for complete details regarding your Health Plan coverage. You may obtain these publications through your employer or by calling our Member Service Call Center at **1-800-464-4000**.

[1]Event Date Information
Please note: The Event Date is not necessarily the effective date of your coverage. Please consult your employer for more information regarding the effective date of your coverage.

Enrollment Reason	Event Date
Loss of Coverage	Date Coverage Was Lost
Moved into Service Area	Move Date
New Hire Enrollment	Date of Hire
New Purchaser	Contract Effective Date
Open Enrollment	Open Enrollment Effective Date
Part-Time to Full-Time	Full-Time Hire Date
Rehire	Date of Rehire
Return from Layoff/LOA	Return Date
Add/Change/Delete Reason	**Event Date**
Acquired Student Status	Date of Acquisition
Address Change	Effective Date of Change
Delete Dependent(s)	Dependent Termination Date
Deceased Member	Deceased Date
Divorce	Date of Divorce
Family Adoption	Date of Adoption
Loss of Coverage	Date Coverage Was Lost
Lost Student Status	Date of Status Change
Marriage Addition	Date of Marriage
Moved into Service Area	Move Date
Name Change	Effective Date of Change
Newborn Additions	Date of Birth
Open Enrollment	Open Enrollment Effective Date

Southern California Service Area for Kaiser Permanente

The Service Area is that portion of Imperial†, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare, and Ventura Counties within the following zip codes:

90000-899	92064-65	92268*†	92382	93040	93301-09
(except	92067-69	92270*	92385-86	93041-44*	93311-13
90704)	92071-72	92274-75*†	92391-94	93060-61*	93380-90
91000-899	92074-75	92276*	92397	93062-66	93501-02
91901-03	92078-79	92277-78*†	92399	93093	93504-05
91908-17	92082-85	92282*	92400-99	93099	93510
91921	92090-93	92284-86*†	92500-32	93203	93518
91931-33	92096	92292*	92543-46	93205-06	93519†
91935	92100-99	92305	92548	93215-16	93531-32
91941-47	92201-03*	92307-08	92551-57	93220	93534-36
91950-51	92210-11*	92313-18	92562-64	93222	93539
91962-63	92220	92320-22	92567	93224-26	93543-44
91976-80	92223	92324-26	92570-72	93238	93550-53
91990-91	92230*	92329	92581-87	93240-41	93560-61
92007-09	92234-36*	92333-37	92595-96	93243	93563
92014	92240-41*	92339-41	92599†	93250-52	93581
92018-27	92252*†	92345-46	92600-899	93261	93584
92029-30	92253*	92350	93000-09*	93263	93586
92033	92254*†	92352	93010-12	93268	93590-91
92037-40	92255*	92354	93015-16	93276	93599
92046	92256*†	92357-59	93020-21	93280	
92049	92258*	92369	93022*	93285	
92051-58	92260-64*	92371-78	93030-35*	93287	

* Subscribers residing in Coachella Valley (greater Palm Springs area) and western Ventura County are required to select an Affiliated Primary Care Physician for themselves and each covered dependent. Members will be contacted after enrollment regarding Affiliated Primary Care Physician selection.

† Not in the Service Area for Kaiser Permanente Senior Advantage members.

Northern California Service Area for Kaiser Permanente

The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba Counties within the following zip codes:

93230-32	94037-45	94922-25	95227	95385-87	95630
93242	94059-67	94926†	95230-31	95390	95632-35
93601-02	94070-71	94927-31	95234	95397	95638-41
93604	94074	94933	95236-37	95401-09	95645
93606-07	94080	94937-42	95240-42	95416	95648
93609	94083	94945-57	95253	95419	95650-52
93611-14	94086-90	94960	95258	95421	95655
93616	94096-99	94963-66	95267	95425	95658-64
93618	94100-99	94970-79	95269	95430-31	95667-74
93623-27	94200-99	94998-99	95290	95433	95676-78
93630-31	94300-99	95002	95296-98	95436	95680-83
93637-39	94400-99	95008-09	95304	95439	95686-88
93643-46	94501-02	95011	95307	95441-42	95690-98
93648-54	94506-31	95013-16	95313	95444	95703
93656-57	94533	95020**-21	95316	95446	95722
93660	94535-53	95026	95319-20	95448	95736
93662	94555-66	95030-33	95323	95450	95741-43
93666-69	94567*	95035-38	95326	95452	95746-47
93673	94568-83	95042	95328-30	95462	95758-59
93675	94585-92	95044	95336-37	95465	95762-63
93700-99	94595-99	95046	95350-58	95471-73	95765
93800-99	94601-99	95050-57	95360-61	95476	95776
94002-03	94700-99	95070-71	95363	95486-87	95798-99
94005	94801-50	95101-99	95366-68	95492	95800-99
94010-12	94901-04	95201-13	95376	95602-05	95903
94014-31	94911-15	95215	95378	95607-26	95961
94035	94920	95219-20	95380-82	95628	

* The Knoxville community, which lies within Pope Valley zip code 94567, is not in the Service Area.

** The Bells Station community, which lies within Gilroy zip code 95020, is not in the Service Area.

† Not in the Service Area for Kaiser Permanente Senior Advantage members.

Service Area as of 8/1/99. Please call the Member Service Call Center at 1-800-777-1256 if you have any questions.

0106-0021-01