Washington Large Group Employee Enrollment/Change Form

KAISER PERMANENTE®

Please print in black or blue ink only.
See instructions on the flap before completing this form.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

This section to be completed by the employer

Company name* _____ Effective date of coverage* ___ / ___ / ___

Medical group no.* _____ Medical subgroup no. _____ Billgroup _____ Date of hire* ___ / ___ / ___

Dental group no. _____ Dental subgroup no. _____ Billgroup _____

Enrollment/change reason – complete if existing group* *(Please check one.)* Event date ___ / ___ / ___

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part-time to full-time ☐ Change _____

☐ Open enrollment ☐ COBRA ☐ State continuation ☐ Other/qualifying event _____

A Employee information *(Employee completes sections A, B, and C.)*

Select benefit type: ☐ Medical _____ *(plan choice)* ☐ Dental _____ *(plan choice)*

Name *(last, first, MI)** _____ Former/maiden name *(if any)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____

Home address* _____ Apt. _____

City _____ State _____ ZIP _____ Email _____

Home phone* _____ Work phone _____

Health record no. *(if any)* _____ Preferred language _____ Ethnicity _____

B Dependent information *(For additional dependents, please use our Washington Group Employee Enrollment/Change Form. If this is for additions of dependents, please include all dependents whom you want to remain on the plan after the change effective date.)*

☐ Spouse ☐ Domestic partner** Name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. (if any) _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

Child name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. (if any) _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

Child name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. (if any) _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

☐ Check here to add additional dependents and attach the Addendum to Employee Enrollment/Change Form.

C 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 back of this form.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee signature* _____ Date ___ / ___ / ___

**Required*

***A person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Washington or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.*

Employer Submission: Fax: 1-866-311-5974. Email: csc-den-roc-group@kp.org
Membership card: Please keep a copy of this form to use as your temporary ID card.

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.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, dentist, health care practitioner, hospital, medical/dental office, or other medical/dental facility. I also acknowledge that KFHPNW 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 an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow any college, university, or educational institution to furnish KFHPNW with information necessary to establish student eligibility under this plan.
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- I understand that all nonemergency services (including services provided under Tier 1 of the Added Choice® plan) are covered only when provided by or arranged by participating providers and participating facilities or Select Providers and Select Facilities.[1] (Added Choice members: See your *Evidence of Coverage* [*EOC*] for providers and facilities covered under Tier 2 and Tier 3 for nonemergency services.)

Obtaining services and prior authorization

If you are enrolling in a traditional copayment, deductible, or high deductible medical or dental plan:

All services must be provided, prescribed, or directed by participating providers or Permanente Dental Associates dentists, except for qualifying emergency and urgent care (outside our service area) or authorized referrals.

If you are enrolling in Added Choice: All Tier 1 services must be provided, prescribed, or directed by Select Providers, except emergency care and urgent care (outside our service area) or authorized referrals.

Prior authorization (all plans): Many services require prior authorization in order to be covered. For example, if you are an Added Choice member, most Tier 2 and/or Tier 3 nonemergency 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. See your *EOC* or contact Member Services to learn which services require prior authorization.

Temporary enrollment identification: Please make a copy of this form. You will soon receive a membership card. Until then, present this form to Member Services, located in most of our facilities, to receive services.

Member Services: For assistance with obtaining services, call Member Services at 1-800-813-2000. For TTY, call 711. For language interpretation services, call 1-800-324-8010.

Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly delay the enrollment process.

By mail:
Kaiser Permanente Membership Administration
P.O. Box 203012
Denver, CO 80220-9012

By fax:[2]
1-866-311-5974

[1] A complete definition of *Select Providers* and *Select Facilities* appears in the *Evidence of Coverage*.

[2] Please limit fax submissions to one enrollment form per transmission.