KAISER PERMANENTE® Southern Colorado Group Enrollment/Change Form

Please review entire form; print or type in black ink only.
Retain pink copy for your records and use as a temporary ID after the effective date.

EMPLOYEE LAST NAME | SOCIAL SECURITY NUMBER | Residence: (check one)
Colorado Springs
Pueblo /Fremont
*See reverse for residence ZIP code lists.

TO BE COMPLETED BY EMPLOYER
COMPANY NAME

GROUP NO. | SUBGROUP NO. | BILLGROUP UNIT | DATE OF HIRE (MM/DD/YYYY) | EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

NEW ENROLLMENT *Check one:*

- New group
- New hire *(complete sections A, B, C, D)*
- Loss of other coverage *(complete sections A, B, C, D)*
- Other *(please specify)* _____
- Open enrollment *(complete sections A, B, C, D)*
- COBRA *(complete sections A, B, C, D)*

Date of event

PLAN *Check one:* HMO | Deductible/Coinsurance HMO | HSA-Qualified Deductible HMO | PPO | HSA-Qualified PPO | PPO Out-of-Area | MultiChoice℠ | Added Choice® (2-Tier) | Added Choice® Triple Option (3-Tier, closed to new groups)

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

DELETE DEPENDENTS *(Complete sections A, B, C, D)*

DATE (MM/DD/YYYY)

- Over age limit
- Divorce
- Deceased
- Other *(please specify)*

_____

ADD DEPENDENTS *(Complete sections A, B, C, D)*

DATE (MM/DD/YYYY)

- Birth
- Adoption*
- Marriage
- Domestic partner *(if applicable)*
- Loss of other coverage
- Other *(please specify)*

OTHER CHANGES

_____

- Name change *(Complete sections A, B, C)*
  - Previous name _____
  - Current name _____
- Address (complete sections A, C)
- Telephone (complete sections A, C)

Are you or any of your dependents eligible for Medicare? If yes, please contact **1-888-681-7878 /** TTY:**1-800-521-4874** for details.

0106-0045-02-r07

*Additional documentation may be required.

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEMBER ID NUMBER | DATE OF BIRTH (MM/DD/YYYY) | MALE FEMALE

PCP ID | Current patient:

Primary care physician (PCP) _____ Yes No

EMPLOYEE ADDRESS

APARTMENT NUMBER | CITY

STATE | ZIP CODE | HOME PHONE | WORK PHONE

PREFERRED SPOKEN OR WRITTEN LANGUAGE (OPTIONAL) | ETHNICITY (OPTIONAL)

B. FAMILY INFORMATION

For additional dependents, please attach a separate sheet and put employee's name at the top.

❑ Check here if you've attached an additional sheet.

ADD DELETE SPOUSE DEPENDENT CHILD OTHER _____

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEMBER ID NUMBER | DATE OF BIRTH (MM/DD/YYYY) | MALE FEMALE

PCP ID | Current patient:

Primary care physician (PCP) _____ Yes No

ADD DELETE DEPENDENT CHILD OTHER _____

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEMBER ID NUMBER | DATE OF BIRTH (MM/DD/YYYY) | MALE FEMALE

PCP ID | Current patient:

Primary care physician (PCP) _____ Yes No

ADD DELETE DEPENDENT CHILD OTHER _____

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEMBER ID NUMBER | DATE OF BIRTH (MM/DD/YYYY) | MALE FEMALE

PCP ID | Current patient:

Primary care physician (PCP) _____ Yes No

EMPLOYEE LAST NAME | SOCIAL SECURITY NUMBER

Are any of your listed dependents over the maximum age? YES NO If yes, please complete the following:

Name(s) (Last, First, MI)	Disabled*	Full-time student	Name of college, university, or trade school
	YES NO	YES NO	
	YES NO	YES NO	

C. Conditions for Enrollment: I have read and agree to the terms and conditions on the reverse side of this enrollment form. Except for: (1) claims filed in Small Claims Court, (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

I hereby apply for Kaiser Permanente membership for myself and eligible family dependents listed on this form. I understand that if I/we, are accepted for membership, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

Employee/Applicant signature Date | Employer signature Date

D. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? YES NO

Name	Insurance carrier name	Policy number	Telephone number

Is your spouse employed? YES NO		Are your children employed? YES NO	
Does your spouse have additional insurance? YES NO		Do your children have additional insurance? YES NO	

EMERGENCY CONTACT

Name and relationship to you	Daytime phone number	Evening phone number

*Additional documentation may be required.