KAISER PERMANENTE®

Group Enrollment/Change Form

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

☐ Denver/Boulder ☐ Colorado Springs ☐ Pueblo ☐ Northern Colorado ☐ Mountain

EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

TO BE COMPLETED BY EMPLOYER

RESIDENCE ZIP CODE (SEE REVERSE FOR ZIP CODE LISTS)

COMPANY NAME

GROUP NO. SUBGROUP NO. BILLGROUP UNIT

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 ○ HMO Plus ○ 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 **1-800-476-2167** for details.

*Additional documentation may be required by your employer.

†The out-of-area tiers of the Point-of-Service plans and the Preferred Provider Organization (PPO) plans are underwritten by the Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc.

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEDICAL RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE | FEMALE

PCP ID | Current patient:

Primary care physician (PCP) ______________________ ○ Yes ○ No

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 | MEDICAL RECORD NUMBER *(IF ANY)* | 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 | MEDICAL RECORD NUMBER *(IF ANY)* | 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 | MEDICAL RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE | FEMALE

PCP ID | Current patient:

Primary care physician (PCP) ______________________ ○ Yes ○ No

*Additional documentation may be required by your employer.

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*
	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.

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

In order to avoid delays in processing your enrollment application, please sign and date the application.

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

*Kaiser Permanente Disabled Dependent certification form will be required for enrollment.

THIS KAISER PERMANENTE GROUP ENROLLMENT / CHANGE FORM MAY BE USED FOR ANY OF THE FOLLOWING REASONS:

- Enrollment/open enrollment
- Change of information
- Cancellation of coverage

Please call Member Services weekdays, 8 a.m. to 6 p.m., if:

- you would like to convert from group to individual coverage, or
- you or any of your dependents are eligible for Medicare, or
- you need help completing this application.

Denver/Boulder	Northern Colorado	Southern Colorado	Mountain Colorado
303-338-3800	1-844-201-5824	1-888-681-7878	1-844-837-6884
711 (TTY for the deaf, hard of hearing, or speech impaired)			

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, call Member Services at **303-338-3800** or **1-800-632-9700** (TTY: **711**). Please print with a black ballpoint pen and press hard. Give one copy of your completed form to your employer. Your employer will mail a copy of the enrollment form to Kaiser Permanente, Membership Administration, P.O. Box 203009, Denver, CO 80220-9009. Keep a copy for temporary identification in case you need care before you receive your Kaiser Permanente ID card.

TO ENROLL

- Employer: Complete section of the form titled "To be completed by employer." Employee: Complete all sections of the form except the section titled "To be completed by employer."
- If you're enrolling current or past Kaiser Permanente members, please fill in Section B. If they were enrolled under a different name, please provide that name.

TO CHANGE MEMBERSHIP INFORMATION*

- If you're adding a dependent because of adoption, fill in the date of the placement for adoption. Attach a copy of the confirmation letter from the adoption agency.
- If you're adding a dependent because of marriage, fill in the date of your marriage.
- If you're adding a Domestic Partner, attach a domestic partner affidavit.
- If you're adding a dependent because you have permanent legal guardianship, attach a copy of your legal guardianship papers.
- If you're deleting a dependent because of death, fill in the date of death.
- If you're changing your name, fill in the previous and current name(s).
- Complete if you or any dependents are eligible for Medicare.

SECTION A—Employee information (Complete all parts of this section if you are enrolling.)

- We need your primary (no P.O. boxes) 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 B—Family information (Complete if you are enrolling or deleting eligible dependents.)

- Fill in the requested information for dependents you want to enroll or delete from coverage. List a primary care physician (PCP) for each member. If you're only enrolling yourself, don't list any dependents in this section. If you're enrolling more than two dependent children, please check the box indicated on the enrollment form and attach an additional sheet. For those children, provide the information requested on the form. (Note: Dependents must be added within 31 days of becoming eligible.)
- Your plan covers children only up to a certain age, unless a child is disabled.
- 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.

SECTION C—Read the "Conditions for enrollment" and sign and date this form.

*To make these changes, additional documentation is required by your employer to confirm eligibility.

SECTION D—(Review and complete if applicable.)

Other coverage information

- Fill in this section if you or any of your dependents currently have, or previously have had, insurance coverage through any other health plan, including Medicare.

Emergency contact

- Provide name, relationship, and phone numbers for your emergency contact.

ONCE YOU HAVE COMPLETED THIS FORM

Provide one copy to your employer.

- If you are a new member, use your copy as temporary identification until your Kaiser Permanente identification card arrives in the mail.
- If you are a current member making changes to your account, keep a copy for your records.
  Call Member Services weekdays, 8 a.m. to 6 p.m

Denver/Boulder	Northern Colorado	Southern Colorado	Mountain Colorado
303-338-3800	1-844-201-5824	1-888-681-7878	1-844-837-6884
711 (TTY for the deaf, hard of hearing, or speech impaired)			
Denver/Boulder surrounding areas (Subject to change)	Northern Colorado and surrounding areas (Subject to change)	Southern Colorado and surrounding areas (Subject to change)	Mountain Colorado and surrounding areas (Subject to change)
80001 80037 80131 80219 80252 80314 80530 80002 80038 80134 80220 80256 80401 80533 80003 80040 80135 80221 80257 80402 80540 80004 80041 80137 80221 80259 80403 80544 80005 80042 80138 80222 80260 80419 80601 80006 80044 80150 80223 80261 80421 80602 80007 80045 80151 80224 80262 80422 80603 80010 80046 80155 80225 80263 80425 80614 80011 80047 80160 80226 80264 80427 80621 80012 80102 80161 80227 80265 80433 80640 80013 80104 80162 80228 80266 80437 80642 80014 80107 80163 80229 80271 80439 80643 80015 80108 80165 80230 80273 80452 80016 80109 80166 80231 80274 80453 80017 80110 80201 80232 80281 80454 80018 80111 80202 80233 80290 80455 80019 80112 80203 80234 80291 80457 80020 80113 80204 80235 80293 80465 80021 80116 80205 80236 80294 80466 80022 80117 80206 80237 80295 80470 80023 80120 80207 80238 80299 80471 80024 80121 80208 80239 80301 80474 80025 80122 80209 80241 80302 80481 80026 80123 80210 80243 80303 80501 80027 80124 80211 80244 80304 80502 80030 80125 80212 80246 80305 80503 80031 80126 80214 80247 80306 80504 80033 80127 80215 80248 80307 80510 80034 80128 80216 80249 80308 80514 80035 80129 80217 80250 80309 80516 80036 80130 80218 80251 80310 80520	69128 80553 69145 80610 80511 80611 80512 80612 80513 80615 80515 80620 80517 80622 80521 80623 80522 80624 80523 80631 80524 80632 80525 80633 80526 80634 80527 80638 80528 80639 80532 80644 80534 80645 80535 80646 80536 80648 80537 80649 80538 80650 80539 80651 80541 80652 80542 80654 80543 80729 80545 80732 80546 80742 80547 80754 80549 82063 80550 82082 80551	80106 80863 80918 80938 80118 80864 80919 80939 80132 80866 80920 80941 80133 80901 80921 80942 80808 80902 80922 80946 80809 80903 80923 80947 80813 80904 80924 80949 80814 80905 80925 80950 80816 80906 80926 80951 80817 80907 80927 80960 80819 80908 80928 80962 80820 80909 80929 80970 80827 80910 80930 80977 80829 80911 80931 80995 80831 80912 80932 80997 80832 80913 80933 80833 80914 80934 80840 80915 80935 80841 80916 80936 80860 80917 80937 Pueblo and Surrounding Areas ZIP codes - 81001 81010 81069 81240 81002 81011 81212 81244 81003 81012 81215 81253 81004 81019 81221 81290 81005 81022 81222 81006 81023 81223 81007 81025 81226 81008 81039 81232 81009 81062 81233	80423 81631 80424 81632 80426 81637 80435 81645 80443 81649 80463 81655 80497 81657 80498 81658 81620

COORDINATION OF BENEFITS

If you and your family are covered by more than one health plan, you may be able to save money while improving your coverage.

Often, when a husband and wife are both employed, they may each have health coverage provided by their employers.
If you are covered by two plans that include a Coordination of Benefits (COB) provision, you may be able to eliminate most of your out-of-pocket expenses for services now only partially covered by those plans.

When you receive services authorized by Kaiser Permanente, we will bill your primary carrier for you and set up a benefit reserve account. Kaiser Permanente will keep track of any savings we receive from your primary carrier and credit it into a benefit reserve account for you. The money in the benefit reserve account is used to reimburse you for out-of-pocket expenses for medical services that are only partially covered by either of your health plans. Incurred expenses applied to the benefit reserve account must occur in the same calendar year.

To take advantage of this benefit, be sure to complete the "Other coverage information" in Section D on the back of the enrollment/change form.

If you have any questions or need more information about Coordination of Benefits, call Patient Business Services at **303-743-5900** (TTY: **711).**

COORDINATION OF BENEFITS AUTHORIZATION

I hereby authorize Kaiser Permanente to bill my spouse's or any other dependent's primary group insurance carrier for all services provided or arranged by Participating Physicians and to coordinate benefits and/or reimbursements with other health or insurance companies. I request that payment be made to Kaiser Permanente on any bills for services furnished for myself or any dependents on my plan. I also authorize Kaiser Permanente to release any information regarding the medical treatment needed for this claim. I further authorize this copy to be used in place of the original.

ADVANCE DIRECTIVES

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes: CRS 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive and will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facilities if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (CRS 15-14-507)

For more information on advance directives, visit **kp.org/advance** directives or call Member Services.

TERMS AND CONDITIONS

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel my membership, and/or refuse to pay claims. I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if this application is accepted by Kaiser Permanente, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

I authorize payroll deduction for whatever amounts are necessary to pay my health plan coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

*Additional documentation may be required.