



Small Business
EMPLOYEE ENROLLMENT

See instructions on page 1 before completing this form. Make a copy for your records.

A TO BE COMPLETED BY EMPLOYER

New group account

Existing account

Company name

Customer ID (if assigned)

Date of coverage to be effective

/ /

Plan selection

Employee classification (if applicable)

Employee name

Enrollment reason (Please check one.) New group account New hire Open enrollment

Part-time to full-time / / Loss of coverage / / Other: Event date / /

If you have an existing account, please fax this form to **858-614-3345** (SCAL), **858-614-3344** (NCAL), or email **csc-sd-sba@kp.org**.

B TO BE COMPLETED BY EMPLOYEE

Have you ever been a member of, or received care from, Kaiser Permanente in California? Yes No

If so, under what medical record number (if known)

Former/Maiden name

Name (Last, First, MI)

Social Security number

Preferred language (optional)

Home address (no P.O. boxes)

City	State	ZIP	County
Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Home phone () -	Office phone () -

If you decline coverage for yourself or an eligible dependent, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

(continues)

C FAMILY INFORMATION (Please list only those family members to be enrolled.)

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
<input type="checkbox"/> Dependent	Date of birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
<input type="checkbox"/> Dependent	Date of birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
<input type="checkbox"/> Dependent	Date of birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
<input type="checkbox"/> Dependent	Date of birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
Do any of your dependents listed above live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the following:			
Name (Last, First, MI)	Address		

D SIGNATURE
KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee signature	Date
X	
Employee name (please print)	Title (please print)

* Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the out-of-network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.