



California Large Commercial Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name <input type="text"/>		Customer ID* <input type="text"/>	Enrollment unit ID* <input type="text"/>
Enrollment unit name/classification <input type="text"/>		Eligibility contact phone <input type="text"/> - <input type="text"/> - <input type="text"/>	
Plan (example: HMO 20, DHMO 500/30) <input type="text"/>	Employee Number/ID <input type="text"/>	Effective date of enrollment/change* (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

<input type="checkbox"/> Enroll subscriber (and dependents)	<input type="checkbox"/> Remove dependent(s) from subscriber account	<input type="checkbox"/> Update address
<input type="checkbox"/> Add dependent(s) to existing subscriber account	<input type="checkbox"/> Change name of subscriber and/or dependent(s)	<input type="checkbox"/> Other <input type="text"/>

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition for obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? Yes No Gender:* Male Female Undeclared

First name* <input type="text"/>	MI* <input type="text"/>	Medical record number (if known) <input type="text"/>
Last name* <input type="text"/>	Social Security number* <input type="text"/> - <input type="text"/> - <input type="text"/>	
Former name/nickname <input type="text"/>	Date of birth* (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Home address* (physical location, no P.O. Box) <input type="text"/>		
City* <input type="text"/>	State* <input type="text"/>	ZIP code* <input type="text"/>
Phone <input type="text"/> - <input type="text"/> - <input type="text"/>		
Mailing address (if different than home) <input type="text"/>		
City <input type="text"/>	State <input type="text"/>	ZIP code <input type="text"/>

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan 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 my 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*.

X Date (mm/dd/yyyy)
 / /

Subscriber signature*

*Field required for all enrollments and changes. [†]Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages 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.

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A-D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 Enroll Remove Change name Relationship to subscriber: Spouse Domestic partner Dependent child
 Has this person ever received treatment at a Kaiser Permanente facility? Yes No Gender:* Male Female Undeclared
 First name* MI* Medical record number (if known)
 Last name* Social Security number*
 Former name/nickname Date of birth* (mm/dd/yyyy)

2 Enroll Remove Change name Relationship to subscriber: Spouse Domestic partner Dependent child
 Has this person ever received treatment at a Kaiser Permanente facility? Yes No Gender:* Male Female Undeclared
 First name* MI* Medical record number (if known)
 Last name* Social Security number*
 Former name/nickname Date of birth* (mm/dd/yyyy)

3 Enroll Remove Change name Relationship to subscriber: Spouse Domestic partner Dependent child
 Has this person ever received treatment at a Kaiser Permanente facility? Yes No Gender:* Male Female Undeclared
 First name* MI* Medical record number (if known)
 Last name* Social Security number*
 Former name/nickname Date of birth* (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber
 Home address* (physical location, no P.O. Box)
 City State ZIP code

If you prefer, you may complete this enrollment/change transaction online by visiting account.kp.org.

*Field required for all enrollments and changes.