KAISER PERMANENTE®

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.

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

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 **1-800-509-7570** for details.

*Additional documentation may be required.

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

White copy - Kaiser Permanente **Yellow copy - Employer** **Pink copy - Employee**

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

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. Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in CRS 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

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.

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

The *white* copy is for Kaiser Permanente—please return it to your employer or mail it to:

Kaiser Permanente
Membership Administration
P.O. Box 203009
Denver, CO 80220-9009

The *yellow* copy is for your employer.

The *pink* copy is for you.

- If you are a new member, use your *pink* 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 the pink copy for your records. Call Member Services weekdays, 8 a.m. to 6 p.m

Denver/Boulder	NorthernColorado	SouthernColorado	MountainColorado
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)

80001 80002 80003 80004 80005 80006 80007 80010 80011 80012 80013 80014 80015 80016 80017 80018 80019 80020 80021 80022 80023 80024 80025 80026 80027 80030 80031 80033 80034 80035 80036
80037 80038 80040 80041 80042 80044 80045 80046 80047 80102 80104 80107 80108 80109 80110 80111 80112 80113 80116 80117 80120 80121 80122 80123 80123 80124 80125 80126 80127 80128 80129
80130 80131 80134 80135 80137 80138 80150 80151 80155 80160 80161 80162 80163 80165 80166 80201 80202 80203 80204 80205 80206 80207 80208 80209 80210 80211 80212 80214 80215 80216 80217
80218 80219 80220 80221 80221 80222 80222 80223 80224 80225 80226 80227 80228 80229 80230 80231 80231 80232 80233 80234 80234 80235 80236 80237 80238 80239 80241 80243 80244 80246 80246
80247 80248 80249 80249 80250 80251 80252 80256 80257 80259 80260 80261 80262 80263 80264 80265 80266 80271 80273 80274 80281 80290 80291 80293 80294 80295 80299 80301 80302 80303 80304
80305 80306 80307 80308 80309 80310 80314 80401 80402 80403 80419 80421 80422 80425 80427 80433 80437 80439 80452 80453 80454 80455 80457 80465 80466 80470 80471 80474 80481 80501 80502
80503 80503 80504 80504 80510 80514 80516 80520 80530 80533 80540 80540 80544 80601 80602 80603 80614 80621 80623 80640 80642 80643

Northern Colorado and surrounding areas (Subject to change)

69128 69145 80511 80512 80515 80517 80521 80522 80523 80524 80525 80526 80527 80528 80532 80534 80535 80536 80537 80538 80539 80541 80542 80543 80545 80546 80547 80549 80550 80551
80553 80610 80611 80612 80615 80620 80622 80624 80631 80632 80633 80634 80638 80639 80644 80645 80646 80648 80649 80650 80651 80652 80654 80729 80732 80742 80754 82063 82082

Southern Colorado and surrounding areas (Subject to change)

80106 80118 80132 80133 80808 80809 80813 80814 80816 80817 80819 80820 80827 80829 80831 80832 80833 80840 80841 80860
80863 80864 80866 80901 80902 80903 80904 80905 80906 80907 80908 80909 80910 80911 80912 80913 80914 80915 80916 80917
80918 80919 80920 80921 80922 80923 80924 80925 80926 80927 80928 80929 80930 80931 80932 80933 80934 80935 80936 80937
80938 80939 80940 80941 80942 80943 80944 80945 80946 80947 80949 80950 80951 80960 80962 80970 80977 80995 80997

Pueblo and Surrounding Areas ZIP codes -

81215 81221 81222 81223 81226 81232 81233 81244 81246
81253 81290 81001 81002 81003 81004 81005 81006 81007
81008 81009 81010 81011 81012 81013 81014 81015 81019
81022 81023 81025 81039 81062 81069 81212 81240 81253

Mountain Colorado and surrounding areas Subject to change)

80423 80424 80426 80435 80443 80463 80497 80498 81620
81631 81632 81637 81645 81649 81655 81657 81658

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.

KAISER PERMANENTE®

Group Enrollment/Change Form

THIS KAISER PERMANENTE 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	NorthernColorado	SouthernColorado	MountainColorado
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 the white and yellow copies of your completed form to your employer. Your employer will mail the white copy of the enrollment form to Kaiser Permanente, Membership Administration, P.O. Box 203009, Denver, CO 80220-9009. Keep the pink 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 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.

(continued on inside panel)