Oregon group employee enrollment/change form

KAISER PERMANENTE®

Please print in black or blue ink only.
See instructions on the flap before completing this form.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Ste. 100, Portland, OR 97232

This section to be completed by the employer

Company name* _____ Effective date of coverage* ___ / ___ / ___

Group no.* _____ Medical subgroup no. _____ Billgroup ___ ___ Date of hire* ___ / ___ / ___

Dental subgroup no. _____ Billgroup ___ ___

PART I:

☐ New group
☐ Existing group

PART II: Enrollment/change reason—complete if existing group* *(Please check one.)* Event date ___ / ___ / ___

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part-time to full-time ☐ Change _____
☐ Open enrollment ☐ COBRA ☐ State continuation ☐ Other _____

A: Employee information *(Employee completes sections A, B, and C.)*

Select benefit type: ☐ Medical _____ *(plan choice)* ☐ Dental _____ *(plan choice)*

Name *(last, first, MI)** _____ Former/maiden name *(if any)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____

Home address* _____ Apt. _____

City _____ State _____ ZIP _____ E-mail _____

Home phone* _____ Work phone _____

Health record no. *(if any)* _____ Preferred language _____ Ethnicity _____

B: Dependent information *(For additional dependents, please use our "Additional Dependent" form.)*

☐ Spouse ☐ Domestic partner** Name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. *(if any)* _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

Child name *(last, first, MI)* _____ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. *(if any)* _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

Child name *(last, first, MI)* _____ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no. _____ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____ Policy no. _____

Health record no. *(if any)* _____ Medicare eligible ☐ Yes ☐ No Medicare ID no. _____

☐ Check here if "Additional Dependent" form is attached.

C: Important—*Your application cannot be processed without your signature. Please read the back of this form before signing.*

If you make an intentional misrepresentation of material fact through misstatement or omission, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form.

Employee signature* _____ Date ___ / ___ / ___

**Required*

***A person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.*