Washington 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., Suite 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 ___ ___

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 ______ Email __________

Home phone* __________ Work phone __________

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

B Dependent information *(For additional dependents, please use our Addendum to Employee Enrollment/Change 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 through age 25* ___ / ___ / ___ 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 through age 25* ___ / ___ / ___ 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 through age 25* ___ / ___ / ___ 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 to add additional dependents and attach the Addendum to Employee Enrollment/Change Form.

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

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.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee signature* ____________________ Date ___ / ___ / ___

**Required*

Employer Submission: Fax: 1-866-311-5974. Email: csc-den-roc-group@kp.org
Membership card: Please keep a copy of this form to use as your temporary ID card.

Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, dentist, health care practitioner, hospital, medical/dental office, or other medical/dental facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow any college, university, or educational institution to furnish KFHPNW with information necessary to establish student eligibility for the student out-of-area benefit and visiting member program under this plan.
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- I understand that all nonemergency services (including services provided under Tier 1 of the Added Choice® plan) are covered only when provided by or arranged by participating providers and participating facilities or Select Providers and Select Facilities.[1] (Added Choice members: See your *Evidence of Coverage* [*EOC*] for providers and facilities covered under Tier 2 and Tier 3 for nonemergency services.)

Obtaining services and prior authorization

If you are enrolling in a traditional copayment, deductible qualified, or high deductible medical or dental plan:

All services must be provided, prescribed, or directed by participating providers or Permanente Dental Associates dentists, except for qualifying emergency and urgent care (outside our service area) or authorized referrals.

If you are enrolling in Added Choice: All Tier 1 services must be provided, prescribed, or directed by Select Providers, except emergency care and urgent care (outside our service area) or authorized referrals.

Prior authorization (all plans): Many services require prior authorization in order to be covered. For example, if you are an Added Choice member, most Tier 2 and/or Tier 3 nonemergency care and procedures provided in a hospital, another care facility, or your home, except for maternity care, must be authorized at least 72 hours in advance. See your *EOC* or contact Member Services to learn which services require prior authorization.

Temporary enrollment identification: Please make a copy of this form. You will soon receive a membership card. Until then, present this form to Member Services, located in most of our facilities, to receive services.

Members Services: For assistance with obtaining services, call Member Services at 1-800-813-2000. For TTY, call 711. For language interpretation services, call 1-800-324-8010.

Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly delay the enrollment process.

By mail:
Kaiser Permanente Membership Administration
P.O. Box 203012
Denver, CO 80220-9012

By fax:[2]
1-866-311-5974

[1] A complete definition of *Select Providers* and *Select Facilities* appears in the *Evidence of Coverage*.

[2] Please limit fax submissions to one enrollment form per transmission.

How to fill out this form

1. Please print legibly in black or blue ink.
2. To be enrolled, you must live or work within the Northwest service area at least 50 percent of the time, unless you are an Added Choice® member.
3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting this form, especially effective dates, as these affect your premium.
4. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. Read section C and the back of the form. Then sign and date the form.
5. Once the form is complete, make a copy for your records. (You will soon get a membership ID card. Until then, you can use a copy of your enrollment form to identify yourself as a member at our facilities.)

All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.

Call Member Services, 8 a.m. to 6 p.m., Monday through Friday. For TTY, call 711. For language interpretation services, call 1-800-324-8010.

Questions?

1-800-813-2000

FWENRL0115

Get connected

Follow the simple steps on the other side to enroll in your plan.

I'm a new member!

Your membership ID card

You will soon receive a membership ID card containing your name and unique eight-digit health record number. You'll want to have this card handy when you call for an appointment, speak to an advice nurse, or come to us for care. If you don't have your ID card before your first appointment, bring a copy of your enrollment form with you.

Transfer your medical records

Transferring your medical records is easy. Download and submit the authorization form at **kp.org/newmember**, and we will take care of the rest. You can also contact Member Services (phone numbers on reverse side) for a form.

Transfer your prescriptions

If you have prescriptions to transfer, you'll want to fill out the Transfer Your Prescriptions Form at **kp.org/newmember** right away. Usually you can receive a one-time refill of a prescription written by a non-participating provider if the medication is on our formulary and your prescription allows for refills.

To order your prescriptions, call the main pharmacy number in your medical office before you need the refill. Certain prescriptions require that you see a participating provider before you can receive a refill. Once you have a prescription written by a participating provider, you can order your prescription refills at **kp.org/rxrefill**. Save additional time and money through our postage-paid Mail-Delivery Pharmacy service, available for most prescriptions.

Register at kp.org

Enjoy around-the-clock, secure access to care with online features that can save you time and money. Once you are registered, you can email your doctor's office, view most lab results, refill prescriptions, schedule routine appointments, and much more. Go to **kp.org/register** to get started. You'll need your eight-digit health record number on your membership ID card to register.

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