California Region Kaiser Permanente Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

Medical Record No. (if known) Social Security No. Birth Date (mm/dd/yyyyy)	TO BE COMPLETED BY EMPLOYER:		
Medical Group Number:	District Name:		Hire Date (mm/dd/yyyy)
Complete this section ONLY if dental, vision and/or life insurance is offered through SISC: Delta Dental Group#;		에 많은 것이 있다는 아무리를 하면 하는 것이 되었다. 그런 사람들은 사람들은 사람들은 사람들은 사람들은 사람들은 사람들은 사람들은	
Delta Dental Group#:	Medical Group Number:	Enrollment Unit:	Change Date (mm/dd/yyyy)
75% premium option list spouse SSII A. ENROLLMENT/CHANGE REASON: (see Change Table for assistance) New group: Yes	Complete this section ONLY if dental, vision and/or life ins	urance is offered through SISC:	
A. ENROLLMENTICHANGE REASON: (see Change Table for assistance) New group: Yes	Delta Dental Group#: Vision Group	oup#:SISC Life Ins C	Group#: Employee Only
New Hire (complete sections A, B, C, D)	75% premium option list spouse SS#		
Health Plan (Check one) HMO Plan Deductible Plan Other	A. ENROLLMENT/CHANGE REASON: (see Change	e Table for assistance) New group:	: Yes 🔲 🔲 No
Name Change (complete sections A, B, C, D) From:			ete sections A, B, C, D)
Name Change (complete sections A, B, C, D) From:	□Loss of Other Coverage (complete sections A, B, C	, D) Other (please specify)	
B. EMPLOYEE: Have you ever been a Kaiser Permanente member?			
SemPLOYEE: Have you ever been a Kaiser Permanente member? Yes			
Medical Record No. (if known) Social Security No. Gender M			
Name (Last, First, MI) Birth Date (mm/dd/yyyy) State ZIP			
Home Address City	1		Gender M
Work Phone	Name (Last, First, MI)	Birth Date (mm/dd/yyyy)	
Ethnicity Preferred Language C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI) Add Delete Spouse Domestic partner Med Den Vision Social Security No. Birth Date (mm/dd/yyyy) Gender Male: Female: Med Den Vision Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Med Den Vision Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Social Security No. Birth Date (mm/dd/yyyy) Medical Record No. Medical Recor	Home Address	City	State ZIP
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Spouse/domestic partner name: Gender Male: Female: Female: Med Den Vision Social Security No. Dependent name: Med Den Vision Social Security No. Dependent name: Social Security No. Dependent name: Med Den Vision Social Security No. Dependent name: Social Security No. Dependent name: Med Den Vision Denet Nation Net Nation Net Nation Net Nation N	C. FAMILY For additional dependents attach a separat	e sheet with employee's name at top. (Las	st, First, MI)
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	Signature required for all Kaiser Permanente Plans		Date

*Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) 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.

(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)