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

Northern Colorado and surrounding areas (Subject to change)

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

Southern Colorado and surrounding areas (Subject to change)

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

Pueblo and Surrounding Areas ZIP codes -

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

Mountain Colorado and surrounding areas Subject to change)

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

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.

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*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)