PRINT SEND RESET

KAISER PERMANENTE®

Hawaii Region Group Enrollment/Change Form

All fields are required unless marked optional. Please see instructions on page 3 on completing this form; print or type in blue or black ink only. Be sure to staple pages 1 and 2 together, also make a copy for yourself and your employer. Use your copy as a temporary ID after the effective date.

TO BE COMPLETED BY EMPLOYER

COMPANY NAME

GROUP NO. SUBGROUP NO. BILLGROUP UNIT EFFECTIVE DATE (MM/DD/YYYY)

ENROLLMENT REASON *Check one:*

- ☐ New hire *(complete sections A, B, C, D)*
  Date of hire *(MM/DD/YYYY)* _____ /_____ /_____
- ☐ Loss of other coverage *(complete sections A, B, C, D)*
- ☐ Cancel all coverage *(empl. and family) (complete section A)*
- ☐ Other *(please specify)* _____
- ☐ Open enrollment *(complete sections A, B, C, D)*
- ☐ COBRA *(complete sections A, B, D)*

Qualifying event

Date of event

PLAN Check one: ☐ HMO ☐ Added Choice

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

DELETE DEPENDENTS (*Complete sections A, B, C, D*)

	DATE
☐ Over age limit	
☐ Divorce	
☐ Deceased	
☐ Other *(please specify)*	

_____

ADD DEPENDENTS (*Complete sections A, B, C, D*)

	DATE
☐ Birth	
☐ Adoption*	
☐ Marriage*	
☐ Loss of other coverage	
☐ Other *(please specify)*	

_____

OTHER CHANGES (*Complete sections A, B, D*)

- ☐ Name change
  Previous name _____
  Current name _____
- ☐ Address (complete sections A, D)
- ☐ Telephone (complete sections A, D)

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 ☐

ADDRESS

APARTMENT NUMBER CITY

STATE ZIP CODE HOME PHONE WORK PHONE

PREFERRED EMAIL ADDRESS (OPTIONAL)

B. FAMILY INFORMATION

EMPLOYEE LAST NAME | SOCIAL SECURITY NUMBER

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ SPOUSE ☐ DOMESTIC PARTNER ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | MEDICAL RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ 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 ☐

ADD ☐ DELETE ☐ MEDICAL ☐ DENTAL ☐ 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 ☐

Do any of your dependents above live at another address? YES ☐ NO ☐ If yes, please complete the following:

Name(s) (Last, First, MI)	Address

Are any of your listed dependents over the maximum age? If yes, please complete the following:

Name(s) (Last, First, MI)	Disabled*	Full-time student	Name of college, university, or trade school
	YES ☐ NO ☐	YES ☐ NO ☐	
	YES ☐ NO ☐	YES ☐ NO ☐	

C. 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

D. Important: Your application cannot be processed without your signature. Please read the reverse side before signing.

I apply for Health Plan membership for the person(s) listed and agree that we shall abide by the *Group Medical and Hospital Service Agreement, Benefit Schedule, Riders,* and Group Face Sheet, including provisions which require that:

1. Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to your Group Medical and Hospital Service Agreement, irrespective of legal theory, must be decided by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
3. I had an opportunity to read the privacy information on the cover sheet of this form.
4. I certify that I am at least 18 years of age and am an authorized agent for all my family members in our agreement to these terms. I also have the legal authority to contract for this medical insurance for each of the person(s) listed on the enrollment form.

Employee/Applicant signature (Required) Date | Employer signature Date

*Additional documentation may be required.

KAISER PERMANENTE GROUP ENROLLMENT/CHANGE FORM INSTRUCTIONS

USE THIS FORM TO:

1. Enroll employee, spouse, and dependents.
2. Add dependents to the plan.
3. Delete employee and dependents from the plan.
4. Change name for employee and dependents.
5. Change address for employee.

DEFINITIONS OF TERMS:

1. Spouse—Subscriber's legally married spouse. State of Hawaii does not recognize common law marriage.
2. Dependents—Legal dependents and dependent children up to age 26, or as specified by your group's contract.
3. Address—Subscriber may enroll if living or working in the Hawaii service area of Oahu, Maui, Kauai, Lanai, Molokai, and Hawaii at the time of enrollment.

TO COMPLETE FORM:

1. Please print firmly using a black or blue ballpoint pen.
2. When adding or deleting dependents, always include the employee/subscriber's name.
3. If dependent's address is different than employee's, please indicate on section B.
4. If you need to use another enrollment form, remember to include the subscriber's name on all forms.
5. Subscriber signature is required. Enrollment will not be processed without a signature.
6. Please refer to employer for correct group number, subgroup number, and billgroup unit (required).
7. Return entire enrollment form to employer.
8. Employer, give pink copy to subscriber to use as a temporary ID card after you sign the enrollment form.
9. Employer, return the remaining pages of the enrollment form to address below:

   Kaiser Permanente
   Membership Administration
   P.O. Box 203011
   Denver, CO 80220-9011

PRIVACY INFORMATION

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes such as quality assessment and improvement, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our "Notice of Privacy Practices" which is on our Web site at kp.org, in our medical offices, or by calling our Customer Service Center. If you have questions or concerns about our privacy practices, please contact our Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).