

Use blue or black ink pen • Do not shrink this form

A. Personal Information

Name of Company		Employer Phone #	Employee Job Title	Full-time Employment Date
Sex <input type="checkbox"/> M <input type="checkbox"/> F Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <i>(Note: If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.)</i>				
Employee Last Name			Employee Social Security Number	
Employee First Name			Date of Birth MO DAY YEAR / / /	Group Number
Residence Address	Apt #	City	State	Zip Code
Home Telephone ()	Email Address	Mailing Address <i>(if different from above)</i>		

B. Medical Benefit (select one plan only)

HMO	POS	PPO	INDEMNITY
<input type="checkbox"/> Plan 10 <input type="checkbox"/> Plan 30 <input type="checkbox"/> Plan 20/1000	<input type="checkbox"/> POS 500 <input type="checkbox"/> POS 1000	<input type="checkbox"/> PPO 500	<input type="checkbox"/> Indemnity Plan

C. Enrollment Information (Complete this section ONLY if you are electing medical and/or dental for yourself or dependents)

	Employee	Spouse/Domestic Partner	Child/Grandchild	Child/Grandchild	Child/Grandchild
Last Name	<input type="checkbox"/> Life only				
First Name					
Relationship to Employee		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.		- -	- -	- -	- -
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		/ /	/ /	/ /	/ /
Disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

* Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

D. Optional Benefits — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

DENTAL COVERAGE

PPO 1500 PPO 1000 FFS 1500 FFS 1000

LIFE INSURANCE

Full Name of Beneficiary	Relationship of Beneficiary	Date of Birth for Beneficiary
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PREMIUM ONLY PLAN (P.O.P.)

I want my portion of eligible insurance premiums paid on a pre-tax basis

PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM

Family Coverage Eligibility Requirements

Who can be covered?

Effective dates

Requirements that **MUST** be met:

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
New Spouse	Coverage begins on the first of month <u>following</u> date of marriage	<ul style="list-style-type: none"> ■ Spouse must be legally married to eligible Employee and the eligible Employee must agree to notify <i>CHOICE</i> Administrators immediately upon termination of the marriage.
New Baby, Dependent Child, Grandchild†	Coverage will begin from the moment of birth through the end of the calendar month of birth, or the mother's hospitalization if she is a member, whichever is later. Premiums for continuation of coverage for the dependent will be charged beginning on the first of the month <u>following</u> the birth.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Born to, a step-child or legal ward of, grandchild† of, or adopted by the eligible Employee or the spouse of the eligible Employee or the Domestic Partner of the eligible Employee ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Adopted Child, Stepchild, Non-Temporary Legal Ward	Coverage is effective on the date the member gains the right to control the dependent's healthcare, and premiums will be charged the first of the month <u>following</u> this date.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Adopted by, stepchild of, or non-temporary legal ward of the Employee ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Domestic Partner	<p><u>During Initial Enrollment or Group's Annual Open Enrollment:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Open Enrollment only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a Domestic Partner will require a State stamped copy of the Certificate of Registered Domestic Partnership within 30 days of issue or a qualifying event (such as involuntary loss of coverage) and a signed affidavit</p>	<p><u>The Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> ■ Share a common residence ■ Not be married under either a statutory or common law or part of a domestic partnership ■ Be 18 years of age or older ■ Share an intimate and committed relationship of mutual caring ■ Both be mentally competent ■ Not be related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify <i>CHOICE</i> Administrators immediately upon termination of the domestic partnership <p>Employee and Domestic Partner must also submit a signed affidavit attesting that the above conditions have been met.</p> <p style="text-align: center;">Employee/Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
New Baby, Dependent Child, Grandchild†, Adopted Child, Non-Temporary Legal Ward of Domestic Partner	See Domestic Partner above	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Born to, dependent child of, step-child of, grandchild† of, adopted by, or non-temporary legal ward of the Domestic Partner ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

† Grandchild may be covered if the parent is a dependent of the covered employee and the parent is also enrolled.

E. Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting this signed application, I agree and understand that the health plan chosen through the Kaiser Permanente Choice Solution program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the participating Kaiser Permanente Choice Solution health plans or their authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize the participating Kaiser Permanente Choice Solution health plans and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the Employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the Employer and considered eligible by my Employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the Employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
- My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and **agree** to provide *CHOICE* Administrators with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the second page of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Kaiser Foundation Health Plan Arbitration Agreement (applies to KFHP only, does not apply to Kaiser Permanente Insurance Company products):

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that the information contained in this application is true and correct.

Employee **SIGN HERE FOR MEDICAL, DENTAL OR LIFE COVERAGE:**

Date:



Print Name

COBRA Applicants:

Please check COBRA type:
 COBRA Cal-COBRA

Indicate Qualifying Event:

Termination of employment Child no longer eligible
 Reduction of hours Divorce/legal separation

Date of Qualifying Event

Medicare entitlement Death of employee

CHOICE Administrators Staff Use

New Group-employee New Hire Open Enrollment Effective Date:

F. Full Time Student Verification

If you wish to include a dependent between the ages of 19 and 24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried
- Financially dependent upon the Employee per IRS guidelines
- Enrolled full-time in an accredited secondary school or college (12 or more units)

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of service/claims submitted on behalf of the dependent.

Employer Name	Employer Group Number (if available)		
Subscriber's Name	Subscriber's Social Security Number		
Student's Name	Name of School	Date Enrolled	

I certify that my above-named dependent is an unmarried student. I hereby request continuation of my child's coverage under my group Health Plan with the understanding that I will notify Kaiser Foundation Health Plan immediately if my child marries or ceases to be a full time student.

Date ____ / ____ / ____ Signature of Subscriber _____

Medical / Dental Waiver

Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.**

A. Personal Information

Name of Company	Employer Phone Number
Employee Last Name	Employee Social Security Number
Employee First Name	Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows:

- 1) **Medical for:** Myself and dependents Spouse/Domestic Partner Child(ren)/Grandchild(ren)
- 2) **Dental for:** Myself and dependents Spouse/Domestic Partner Child(ren)/Grandchild(ren)

C. Reason


Required only if employee waiving coverage

- 1) **Reason waiving Medical:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)
- 2) **Reason waiving Dental:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)

D. Signature

I understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE: 	Date
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