



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.

EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

Residence: (check one)

Colorado Springs

Pueblo /Fremont

*See reverse for residence

ZIP code lists.

TO BE COMPLETED BY EMPLOYER

COMPANY NAME

GROUP NO.

SUBGROUP NO.

BILLGROUP UNIT

DATE OF HIRE (MM/DD/YYYY)

EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

NEW ENROLLMENT Check one:

New group

New hire (complete sections A, B, C, D)

Loss of other coverage (complete sections A, B, C, D)

Other (please specify) _____

Open enrollment (complete sections A, B, C, D)

COBRA (complete sections A, B, C, D)

Date of event

PLAN Check one:

HMO

Deductible/Coinsurance HMO

HSA-Qualified Deductible HMO

PPO

HSA-Qualified PPO

PPO Out-of-Area

MultiChoiceSM

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 **1-888-681-7878 / TTY:1-800-521-4874** for details.

*Additional documentation may be required.



A. EMPLOYEE INFORMATION

LAST NAME FIRST NAME MI SUFFIX
 SOCIAL SECURITY NUMBER MEMBER ID NUMBER DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 PCP ID Current patient:
 Primary care physician (PCP) _____ Yes No
 EMPLOYEE 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 MEMBER ID NUMBER 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 MEMBER ID NUMBER 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 MEMBER ID NUMBER DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 PCP ID Current patient:
 Primary care physician (PCP) _____ Yes No



EMPLOYEE LAST NAME	SOCIAL SECURITY NUMBER
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Are any of your listed dependents over the maximum age? YES <input type="checkbox"/> NO <input type="checkbox"/>				If yes, please complete the following:			
Name(s) (Last, First, MI)	Disabled*	Full-time student	Name of college, university, or trade school				
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					

C. Conditions for Enrollment: I have read and agree to the terms and conditions on the reverse side of this enrollment form. Except for: (1) claims filed in Small Claims Court, (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbitrator. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

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
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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 <input type="checkbox"/> NO <input type="checkbox"/>	Are your children employed? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Does your spouse have additional insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>	Do your children have additional insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>		

EMERGENCY CONTACT

Name and relationship to you	Daytime phone number	Evening phone number

*Additional documentation may be required.

