KAISER PERMANENTE®

Account Change Form

TO BE COMPLETED BY EMPLOYER **Please print or type in black ink only. Read instructions on the back. Make a copy for your records.**

Company name *(required)* _____ Date of hire *(required)* _____

Group number *(required)* _____ Enrollment unit/plan *(required)* _____ Effective date of coverage *(required)* _____

REQUESTED CHANGE(S)

❑ Add dependents *(Complete sections A, B, C.)* ❑ Delete dependents *(Complete sections A, B.)*

Reason _____ *(See "Change reason table.")* Event date _____

❑ Name change *(Complete sections A, B, C.)* From _____ To _____

❑ Address *(Complete Section A.)* _____

❑ Telephone *(Complete Section A.)* _____

A. EMPLOYEE INFORMATION

Name (Last, First, MI) _____ Medical record number _____

Home address _____ Apt. no. _____ City _____ State _____ ZIP _____

Home phone _____ Work phone _____ Social Security number (last four digits) _____

E-mail _____

B. FAMILY INFORMATION

For additional dependents, please attach a separate sheet and put the employee's name at the top.

❑ Spouse ❑ Domestic partner Name (Last, First, MI): Former last name *(if any)*:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number (last four digits) Medical record number
❑ Child ❑ Student Name (Last, First, MI): Relationship:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number (last four digits) Medical record number
❑ Child ❑ Student Name (Last, First, MI): Relationship:	Gender ❑ M ❑ F Date of birth MM/DD/YY	Social Security number (last four digits) Medical record number

Do any of your dependents listed above live at another address? ❑ Yes ❑ No If Yes, complete the following:

Name (Last, First, MI) _____ Address _____

C. Kaiser Foundation Health Plan Arbitration Agreement: 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, my relatives, 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 our 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.*

X _____

Employee signature (Use black ink.) Date

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General instructions

1. Please print legibly in black ink.
2. The employer must complete the first section labeled "To be completed by employer."
3. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect health plan premiums.
4. The employee/subscriber must complete sections A through C. See right column for detailed instructions.
5. Be sure to sign and date the bottom of the form.
6. Once the form is complete (including completed employer section), the subscriber should make a copy for his/her records.
7. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing sections

To be completed by employer: The employer must complete all fields to ensure we have correct account and reason information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates as these affect health plan premiums.

Requested changes: The subscriber must always complete this section, even when making minor changes to the account. This ensures our information is current. Please mark the box if your address or telephone number is new.

Section A: The subscriber must complete this section.

Section B: The subscriber must indicate the requested change being made to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an *overage dependent* attending school. Please contact your employer regarding the employer's rules for overage dependent students. A completed *Student Certification* form may be required.

Section C: The subscriber must complete this section.

Change reason table

Add dependent reason	Event date
Acquired student status*	Date student status was obtained
Family adoption*	Date of adoption
Loss of coverage	Date coverage was lost
New spouse (marriage)*	Date of marriage
Moved into service area	Move date
Newborn addition	Date of birth
Open enrollment	Open enrollment effective date
Delete dependent reason	**Event date**
Loss of student status	Date of status change
Divorce	Date of divorce
Member deceased*	Date of death
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

*Additional documentation may be required.