

**SECTION 1: REGION WHERE COVERAGE IS REQUESTED**

Please select applicable region. For the Kaiser Permanente region selected, the company that will be issuing coverage for that region is identified.

**CALIFORNIA**

Kaiser Foundation Health Plan, Inc. (KFHP)

**California** (KFHP-CA)

One Kaiser Plaza, Oakland, CA 94612

**Northern California**
**Southern California**

Group number \_\_\_\_\_

Kaiser Permanente Insurance Company (KPIC)\*

**COLORADO**

Kaiser Foundation Health Plan of Colorado  
(KFHP-CO)

10350 E. Dakota Ave., Denver, CO 80247

**LARGE GROUP ONLY** (SG must use CO DORA Form)

Group number \_\_\_\_\_

Kaiser Permanente Insurance Company (KPIC)\*

**GEORGIA**

Kaiser Foundation Health Plan of Georgia, Inc.  
(KFHP-GA)

3495 Piedmont Road, Atlanta, GA 30305

Group number \_\_\_\_\_

Kaiser Permanente Insurance Company (KPIC)\*

**HAWAII**

Kaiser Foundation Health Plan, Inc. (KFHP-HI)

711 Kapiolani Blvd., Honolulu, HI 96813

Group number \_\_\_\_\_

Kaiser Permanente Insurance Company (KPIC)\*

**MID-ATLANTIC STATES**

Kaiser Foundation Health Plan of the Mid-Atlantic  
States, Inc. (KFHP-MAS)

4000 Garden City Drive, Hyattsville, MD 20785

**District of Columbia**
**Maryland**
**Virginia**

Group number \_\_\_\_\_

Kaiser Permanente Insurance Company (KPIC)\*

**NORTHWEST**

Kaiser Foundation Health Plan of the Northwest  
(KFHP-NW)

500 NE Multnomah St., Suite 100, Portland, OR 97232

**Oregon**
**Washington** (Clark and Cowlitz Counties)\*\*

Group number \_\_\_\_\_

**WASHINGTON**

Kaiser Foundation Health Plan of Washington  
(KFHP-WA)\*\*\*

Kaiser Foundation Health Plan of Washington  
Options, Inc. (KFHP-WAO)\*\*\*\*

2715 Naches Ave SW, Renton, WA 98057

Group number \_\_\_\_\_

Delta Dental of Washington

\*Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Oakland, California 94612.

\*\*Kaiser Foundation Health Plan of the Northwest (KFHP-NW) is licensed as a Health Care Service Contractor in Washington and Oregon.

\*\*\*Kaiser Foundation Health Plan of Washington (KFHP-WA) is licensed as a Health Maintenance Organization.

\*\*\*\*Kaiser Foundation Health Plan of Washington Options, Inc. (KFHP-WAO) is licensed as a Health Care Service Contractor.

Please print in blue or black ink only.

**A. EMPLOYER INFORMATION** (to be completed by subscriber)

Select Region:\* ☐ California ☐ Georgia ☐ Mid-Atlantic States (MD, VA, and DC) ☐ Washington  
☐ Colorado ☐ Hawaii ☐ Northwest (OR and Clark and Cowlitz counties, WA)

|                                              |                |                |                                |
|----------------------------------------------|----------------|----------------|--------------------------------|
| Company name*                                | Group ID*      | Billgroup name | Billgroup ID                   |
| Effective date of enrollment/change:*<br>/ / | Subgroup Name* | Subgroup ID*   | Classification (if applicable) |

For Washington and Northwest (OR and Clark and Cowlitz counties, WA) regions, provide the following:

|                                              |                     |                    |                      |
|----------------------------------------------|---------------------|--------------------|----------------------|
| Family or Adult Dental (19 years and older): | Dental Billgroup ID | Dental Subgroup ID | Dental Subgroup Name |
| Pediatric Dental (18 years and younger):     | Dental Billgroup ID | Dental Subgroup ID | Dental Subgroup Name |

**B. What are the changes requested?\*** (Subscriber: Mark the box for the change you are requesting.)

Subscriber to fill out their information in Section C and for the affected dependents in Section D.

| Regular Plan Transactions                                                                                                                                                                                                                                                                                                                        | COBRA Plan Transactions                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Enroll Subscriber (and dependents)<br><input type="checkbox"/> Transfer Subscriber<br>(automatically includes dependents)<br>Current Subgroup ID _____<br>Current Billgroup ID _____<br><input type="checkbox"/> Terminate Subscriber<br>(automatically includes dependents)                                            | <input type="checkbox"/> Enroll Subscriber (and dependents)<br><input type="checkbox"/> Transfer Subscriber<br>(automatically includes dependents)<br>Current Subgroup ID _____<br>Current Billgroup ID _____<br><input type="checkbox"/> Terminate Subscriber<br>(automatically includes dependents) |
| <input type="checkbox"/> Reinstate Subscriber<br>(dependents termed at the<br>same time as Subscriber will<br>also be reinstated)<br><input type="checkbox"/> Add dependent(s) only<br><input type="checkbox"/> Remove dependent(s) only<br><input type="checkbox"/> Reinstate dependent(s) only<br><input type="checkbox"/> Demographic Changes | <input type="checkbox"/> Add dependent(s) only<br><input type="checkbox"/> Remove dependent(s) only<br><input type="checkbox"/> Demographic Changes                                                                                                                                                   |

**C. SUBSCRIBER/EMPLOYEE INFORMATION**

For Washington and Northwest Regions: ☐ Elect Family or Adult Dental (19 years and older) ☐ Waive Family or Adult Dental  
☐ Elect Pediatric Dental (18 years and younger)

|                                    |                                                                                                                                                                                 |            |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Preferred Language                 | Former Name/Nickname/Maiden Name                                                                                                                                                |            |
| First Name*                        | Middle Initial                                                                                                                                                                  | Last Name* |
| Social Security Number             |                                                                                                                                                                                 |            |
| Date of Birth* (mm/dd/yyyy)<br>/ / | Gender*<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Other <input type="checkbox"/> X-Gender |            |

|                                                                       |               |      |        |                    |
|-----------------------------------------------------------------------|---------------|------|--------|--------------------|
| Home/Physical Address*                                                |               |      |        | Apt/Unit/Box/Suite |
| City*                                                                 | State*        | ZIP* | County |                    |
| P.O. Box or Mailing Address (if different than home/physical address) |               |      |        | Apt/Unit/Box/Suite |
| City                                                                  | State         | ZIP  | County |                    |
| Primary Phone (mobile if available)                                   | Email Address |      |        |                    |

## D. Dependents Affected (List all dependent(s), starting with Spouse/Domestic Partner, if applicable. For dependents age 18 or older, provide phone number and email.

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Transaction Type*<br><input type="checkbox"/> Enroll<br><input type="checkbox"/> Remove<br><input type="checkbox"/> Reinstate<br><input type="checkbox"/> Demographic Update | Dental Election (for Washington and Northwest regions)*<br><input type="checkbox"/> Elect Family or Adult Dental (19 years and older)<br><input type="checkbox"/> Elect Pediatric Dental (18 years and younger)<br><input type="checkbox"/> Waive Family or Adult Dental | Relationship to Subscriber*<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Domestic Partner<br><input type="checkbox"/> Family Member<br><input type="checkbox"/> Grandchild |
| Preferred Language                                                                                                                                                           | Former Name/Nickname/Maiden Name                                                                                                                                                                                                                                         |                                                                                                                                                                                              |
| First Name*                                                                                                                                                                  | Middle Initial                                                                                                                                                                                                                                                           | Last Name*                                                                                                                                                                                   |
| Social Security Number                                                                                                                                                       |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |
| Date of Birth* (mm/dd/yyyy)<br><br>/ /                                                                                                                                       | Gender*<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Other <input type="checkbox"/> X-Gender                                                                                          |                                                                                                                                                                                              |
| Does dependent live at an address different from subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                        |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |
| If Yes, provide Home/Physical Address:*                                                                                                                                      |                                                                                                                                                                                                                                                                          | Apt/Unit/Box/Suite                                                                                                                                                                           |
| City*                                                                                                                                                                        | State*                                                                                                                                                                                                                                                                   | ZIP*                                                                                                                                                                                         |
| County                                                                                                                                                                       |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |
| Primary Phone (mobile if available)                                                                                                                                          | Email Address                                                                                                                                                                                                                                                            |                                                                                                                                                                                              |

**D. DEPENDENTS** (continued)

|                                                                                                                                                         |  |                                                                                                                                                                                                               |                                  |                                                                               |                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------|--------------------|
| Transaction Type*                                                                                                                                       |  | Dental Election (for Washington and Northwest regions)                                                                                                                                                        |                                  | Relationship to Subscriber*                                                   |                    |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Remove<br><input type="checkbox"/> Reinstate<br><input type="checkbox"/> Demographic Update |  | <input type="checkbox"/> Elect Family or Adult Dental (19 years and older)<br><input type="checkbox"/> Elect Pediatric Dental (18 years and younger)<br><input type="checkbox"/> Waive Family or Adult Dental |                                  | <input type="checkbox"/> Family Member<br><input type="checkbox"/> Grandchild |                    |
| Preferred Language                                                                                                                                      |  |                                                                                                                                                                                                               | Former Name/Nickname/Maiden Name |                                                                               |                    |
| First Name*                                                                                                                                             |  | Middle Initial                                                                                                                                                                                                |                                  | Last Name*                                                                    |                    |
| Social Security Number                                                                                                                                  |  |                                                                                                                                                                                                               |                                  |                                                                               |                    |
| Date of Birth* (mm/dd/yyyy)<br><br>/ /                                                                                                                  |  | Gender*<br><br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Other <input type="checkbox"/> X-Gender                           |                                  |                                                                               |                    |
| Does dependent live at an address different from subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |  |                                                                                                                                                                                                               |                                  |                                                                               |                    |
| If Yes, provide Home/Physical Address:*                                                                                                                 |  |                                                                                                                                                                                                               |                                  |                                                                               | Apt/Unit/Box/Suite |
| City*                                                                                                                                                   |  | State*                                                                                                                                                                                                        | ZIP*                             | County                                                                        |                    |
| Primary Phone (mobile if available)                                                                                                                     |  | Email Address                                                                                                                                                                                                 |                                  |                                                                               |                    |

**D. DEPENDENTS** (continued)

|                                                                                                                                                         |  |                                                                                                                                                                                                               |      |                                                                               |                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------|--------------------|
| Transaction Type*                                                                                                                                       |  | Dental Election (for Washington and Northwest regions)                                                                                                                                                        |      | Relationship to Subscriber*                                                   |                    |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Remove<br><input type="checkbox"/> Reinstate<br><input type="checkbox"/> Demographic Update |  | <input type="checkbox"/> Elect Family or Adult Dental (19 years and older)<br><input type="checkbox"/> Elect Pediatric Dental (18 years and younger)<br><input type="checkbox"/> Waive Family or Adult Dental |      | <input type="checkbox"/> Family Member<br><input type="checkbox"/> Grandchild |                    |
| Preferred Language                                                                                                                                      |  | Former Name/Nickname/Maiden Name                                                                                                                                                                              |      |                                                                               |                    |
| First Name*                                                                                                                                             |  | Middle Initial                                                                                                                                                                                                |      | Last Name*                                                                    |                    |
| Social Security Number                                                                                                                                  |  |                                                                                                                                                                                                               |      |                                                                               |                    |
| Date of Birth* (mm/dd/yyyy)<br>/ /                                                                                                                      |  | Gender*<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Other <input type="checkbox"/> X-Gender                               |      |                                                                               |                    |
| Does dependent live at an address different from subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |  |                                                                                                                                                                                                               |      |                                                                               |                    |
| If Yes, provide Home/Physical Address:*                                                                                                                 |  |                                                                                                                                                                                                               |      |                                                                               | Apt/Unit/Box/Suite |
| City*                                                                                                                                                   |  | State*                                                                                                                                                                                                        | ZIP* | County                                                                        |                    |
| Primary Phone (mobile if available)                                                                                                                     |  | Email Address                                                                                                                                                                                                 |      |                                                                               |                    |

|                                                                                                                                                         |  |                                                                                                                                                                                                               |      |                                                                               |                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------|--------------------|
| Transaction Type*                                                                                                                                       |  | Dental Election (for Washington and Northwest regions)                                                                                                                                                        |      | Relationship to Subscriber*                                                   |                    |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Remove<br><input type="checkbox"/> Reinstate<br><input type="checkbox"/> Demographic Update |  | <input type="checkbox"/> Elect Family or Adult Dental (19 years and older)<br><input type="checkbox"/> Elect Pediatric Dental (18 years and younger)<br><input type="checkbox"/> Waive Family or Adult Dental |      | <input type="checkbox"/> Family Member<br><input type="checkbox"/> Grandchild |                    |
| Preferred Language                                                                                                                                      |  | Former Name/Nickname/Maiden Name                                                                                                                                                                              |      |                                                                               |                    |
| First Name*                                                                                                                                             |  | Middle Initial                                                                                                                                                                                                |      | Last Name*                                                                    |                    |
| Social Security Number                                                                                                                                  |  |                                                                                                                                                                                                               |      |                                                                               |                    |
| Date of Birth* (mm/dd/yyyy)<br>/ /                                                                                                                      |  | Gender*<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Other <input type="checkbox"/> X-Gender                               |      |                                                                               |                    |
| Does dependent live at an address different from subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |  |                                                                                                                                                                                                               |      |                                                                               |                    |
| If Yes, provide Home/Physical Address:*                                                                                                                 |  |                                                                                                                                                                                                               |      |                                                                               | Apt/Unit/Box/Suite |
| City*                                                                                                                                                   |  | State*                                                                                                                                                                                                        | ZIP* | County                                                                        |                    |
| Primary Phone (mobile if available)                                                                                                                     |  | Email Address                                                                                                                                                                                                 |      |                                                                               |                    |

## FRAUD STATEMENT

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To the best of my knowledge, the information I have provided in this form is true, complete, and correct. I understand that any fraudulent or false information knowingly supplied by me may allow Kaiser Permanente to recover payments made, terminate enrollment, and/or refuse to pay claims. I hereby apply for enrollment for myself and/or my eligible family dependents listed in this form. I understand that if this enrollment form is accepted by Kaiser Permanente, the terms and conditions of our coverage and benefits will be set forth in the applicable group contract and health plan coverage document (e.g. *Evidence of Coverage* or *Certificate of Insurance*).

If you commit fraud or make an intentional misrepresentation of material fact through misstatement, inaccuracy, or omission, then the Kaiser entity(ies) issuing coverage (as indicated on the first page of this enrollment form) may, as permitted by applicable law, terminate coverage (retroactively or prospectively) or modify coverage (including but not limited to the amount of premium owed) and/or take any other legal action available to it by law. In addition, it may be a crime to knowingly provide false, incomplete, or misleading information to Kaiser Permanente for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

I acknowledge by my signature that (1) the information I have supplied on this form is true, complete, and correct and (2) I agree to the requirements, terms, conditions, limitations, and provisions regarding eligibility and enrollment for the Kaiser Permanente health plan coverage that my dependents and I will be enrolled in.

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Subscriber Signature\*

Date

X

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Subscriber Print Name

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By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information, visit [healthy.kaiserpermanente.org/termsconditions](https://www.kaiserpermanente.org/termsconditions).

## CALIFORNIA ARBITRATION AGREEMENT (For California Region Enrollees only)

If you decline coverage for yourself or an eligible dependent, you can only enroll during an annual open enrollment period established by your employer, or during a special enrollment period if you've experienced a qualifying event. You must request coverage within 60 days of a qualifying event. Special enrollment qualifying events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court order that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that's serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that's been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual didn't enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

### KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT<sup>†</sup>

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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](#).

Subscriber Signature\*

Date

X

\*Field required for all enrollments and changes. <sup>†</sup>Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

## **HAWAII ARBITRATION AGREEMENT** (For Hawaii Region Enrollees only)

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### **A. BINDING ARBITRATION**

Except as provided below, any and all claims, disputes, or causes of action arising out of or related to this Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Service Agreement.

1. This includes but is not limited to any claim asserted:

- (a) By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;
- (b) On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Service Agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
- (c) By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
  - (i) Kaiser Foundation Health Plan, Inc.,
  - (ii) Kaiser Foundation Hospitals,
  - (iii) Hawaii Permanente Medical Group, Inc.,
  - (iv) The Permanente Federation, LLC,
  - (v) The Permanente Company, LLC,
  - (vi) Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv) or (v) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

2. Notwithstanding any provisions to the contrary in this Service Agreement, the following claims shall not be subject to mandatory arbitration:

- (a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- (b) actions for appointment of a legal guardian of a person or property subject to probate laws;
- (c) purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this Service Agreement (such as temporary restraining orders, and emergency court orders).

### **B. INITIATING ARBITRATION**

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in section VII-J of this Service Agreement. The arbitrators shall have jurisdiction only over persons and entities actually served.

### **C. ARBITRATION PROCEEDINGS**

1. Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30 day period noted above.

2. Within 30 calendar days after notice to Dispute Prevention and Resolution, Inc., the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than \$25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

**HAWAII ARBITRATION AGREEMENT** (continued)

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3. Limited civil discovery shall be permitted only for

- (a) production of documents that are relevant and material,
- (b) taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
- (c) independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

4. Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

5. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

6. The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

7. In claims involving benefits and coverage due under this Service Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to *de novo* review.

8. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.

9. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

**D. GENERAL PROVISIONS**

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Service Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Service Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Service Agreement shall supercede those in any prior Service Agreement.

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Your application cannot be processed without your signature. Please read page 5 before signing. I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations and provisions described on pages 4 through 8.

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Subscriber signature\*

X

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Date