2025 Addendum to Washington Large Group Employee Enrollment/Change

KAISER PERMANENTE®

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Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

This form must accompany the Washington Large Group Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Washington Large Group Employee Enrollment/Change Form.

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name[1] ______________________ Effective date of coverage[1] ____ / ____ / ____

Group #[1] __________ Medical subgroup # __________ Medical billgroup __________

Dental subgroup # ______________________ Dental billgroup ______________________

A Employee information *(Employee completes sections A, B, and C.)*

Legal name *(last, first, MI)*[1] ______________________

Former/maiden name *(if any)* __________ Date of birth[1] ____ / ____ / ____ Social Security # __________

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) __________

B Dependent information

Dependent (child) legal name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ____ / ____ / ____

Social Security # ______________________ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) __________ Mobile phone __________ Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy # __________ Medical record # (if any) __________

Dependent (child) legal name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ____ / ____ / ____

Social Security # ______________________ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) __________ Mobile phone __________ Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy # __________ Medical record # (if any) __________

Dependent (child) legal name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ____ / ____ / ____

Social Security # ______________________ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) __________ Mobile phone __________ Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy # __________ Medical record # (if any) __________

Dependent (child) legal name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ____ / ____ / ____

Social Security # ______________________ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) __________ Mobile phone __________ Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy # __________ Medical record # (if any) __________

☐ Check here if another Addendum to Washington Large Group Employee Enrollment/Change Form is attached.

C Important

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee signature[1] ______________________ Date ____ / ____ / ____

[1] Required.

[2] Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental disability, mental illness, or physical disability.

Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.