

EMPLOYER: PLEASE COMPLETE THIS SECTION. Effective date _____ Termination date _____ Group name _____ Group number _____ Selected health plan _____ Pay location (if applicable) _____	Original date of hire _____/_____/_____ Date of rehire _____/_____/_____ Date transferred from part time (p/t) to full time (f/t) _____/_____/_____ Hours worked per week _____ If retired, date of retirement _____/_____/_____	Choose one: <input type="checkbox"/> Open enrollment <input type="checkbox"/> Add dependent(s) <input type="checkbox"/> New employee <input type="checkbox"/> Remove coverage ___ Employee <input type="checkbox"/> Address/name change ___ Dependent(s) <input type="checkbox"/> Qualifying event _____ Date processed ___/___/___ by _____	<input type="checkbox"/> Transfer to COBRA Start date ___/___/___ <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months <input type="checkbox"/> Waive Delta Dental <input type="checkbox"/> I elect to waive dental Reminder to employers: For groups already enrolled in direct policies, enrollment and changes can be made online via our Business Portal.
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EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Mobile phone* (_____) _____
 (Last name) (First name) (M.I.)

Resident address _____ Home phone* (_____) _____
 (Street) (City) (State) (ZIP)

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse/domestic partner (if applicable) _____

* I understand that Kaiser Permanente may contact me via email or text messaging.

For health plan internal use only	Check one		Please print Last name First name M.I.	Social Security number	Male/Female	Birthdate (MM/DD/YY)	Relationship to employee
	Add	Remove					
			Self (unless waived, dental coverage will apply to all enrolled members of a family)				
			Spouse/domestic partner/dependent (circle one)				
			Dependent				
			Dependent				
			Dependent				

 (Signature of employee) (Date signed)

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. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. In Washington state, a registered domestic partner is treated the same as a spouse. If children of the primary insured are covered, children of a domestic partner are eligible for coverage on the same basis. Dental enrollment will mirror enrollment in medical unless waived by the entire family. All health plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057. Optional dental offered by Delta Dental of Washington, 400 Fairview Ave N., Suite #800, Seattle, WA 98109.