



Return completed form to  
P.O. Box 23219, San Diego, CA 92193-9921

## 2026 Employee enrollment and change form

**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:

☐ Open enrollment      ☐ Add dependent(s)

☐ New employee      ☐ Remove coverage

☐ Address/name change      ☐ Employee  
☐ Dependent(s)

☐ Qualifying event\_\_\_\_\_

Date processed \_\_\_\_/\_\_\_\_/\_\_\_\_ by \_\_\_\_\_

☐ Transfer to COBRA

Start date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ 18 months☐ 36 months

**Reminder to employers:**  
For groups already enrolled  
in direct policies, enrollment  
and changes can be made  
online via our Business Portal.

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						
			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. All 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.