Oregon group employee enrollment/change form

See instructions on pages 2–3 before completing this form.

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This section to be completed by the employer.

Company name* ______ Effective date of coverage* ____ / ____ / ____

Group no.* ______ Medical subgroup no. ______ Billgroup ___ ___ Date of hire* ____ / ____ / ____

Dental subgroup no. ______ Billgroup ___ ___

PART I:

O New group

O Existing group

PART II: Enrollment/change reason—complete if existing group* *(Please check one.)* Event date ____ / ____ / ____

O New hire O Newborn O Loss of coverage O Part-time to full-time O Change ______

O Open enrollment O COBRA O State continuation O Other ______

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

Select benefit type: O Medical ______ *(plan choice)* O Dental ______ *(plan choice)*

Name *(last, first, MI)** ______ Former/maiden name *(if any)* ______

Gender* O M O F Date of birth* ____ / ____ / ____ Social Security no. ______

Home address* ______ Apt. ______

City ______ State ____ ZIP ____ E-mail ______

Home phone* ______ Work phone ______

Health record no. *(if any)* ______ Preferred language ______ Ethnicity ______

B Dependent information *(For additional dependents, please use our "Additional Dependent" form.)*

O Spouse O Domestic partner** Name *(last, first, MI)* ______ Disabled O Yes O No

Gender* O M O F Date of birth* ____ / ____ / ____ Social Security no. ______ O Medical O Dental

Other health insurance O Yes O No Insurance co. ______ Policy no. ______

Health record no. *(if any)* ______ Medicare eligible O Yes O No Medicare ID no. ______

Child name *(last, first, MI)* ______ O Full-time student Disabled O Yes O No

Gender* O M O F Date of birth* ____ / ____ / ____ Social Security no. ______ O Medical O Dental

Other health insurance O Yes O No Insurance co. ______ Policy no. ______

Health record no. *(if any)* ______ Medicare eligible O Yes O No Medicare ID no. ______

Child name *(last, first, MI)* ______ O Full-time student Disabled O Yes O No

Gender* O M O F Date of birth* ____ / ____ / ____ Social Security no. ______ O Medical O Dental

Other health insurance O Yes O No Insurance co. ______ Policy no. ______

Health record no. *(if any)* ______ Medicare eligible O Yes O No Medicare ID no. ______

Child name *(last, first, MI)* ______ O Full-time student Disabled O Yes O No

Gender* O M O F Date of birth* ____ / ____ / ____ Social Security no. ______ O Medical O Dental

Other health insurance O Yes O No Insurance co. ______ Policy no. ______

Health record no. *(if any)* ______ Medicare eligible O Yes O No Medicare ID no. ______

O Check here if "Additional Dependent" form is attached.

C Important—*Your application cannot be processed without your signature. Please read pages 2–3 of this form 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 2–3 of this form.

Employee signature* ______ Date ____ / ____ / ____

*Required

**A person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.*

Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow any college, university, or educational institution to furnish KFHPNW with information necessary to establish student eligibility under this plan.
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- I understand that all non-emergency services (including services provided under Tier 1 of Added Choice®) are covered only when provided by or arranged by Participating Providers and Participating Facilities or Select Providers and Select Facilities. (Added Choice members: See your *Evidence of Coverage* [*EOC*] for providers and facilities covered under Tier 2 and Tier 3 for non-emergency services.)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after a marriage, and within 60 days for a birth, adoption, or placement for adoption (if an additional premium is not required to add a child, this requirement is waived).

To request special enrollment or obtain more information, contact Membership Services at one of the phone numbers listed below.

Obtaining services and prior authorization

If you are enrolling in a Traditional, Deductible (HSA-Compatible), or High Deductible medical or dental plan: All services must be provided, prescribed, or directed by Participating Providers or Permanente Dental Associates dentists, except for qualifying emergency and urgent care (outside our service area) or authorized referrals.

If you are enrolling in Added Choice: All Tier 1 services must be provided, prescribed, or directed by Select Providers, except emergency care and urgent care (outside our service area) or authorized referrals.

Prior authorization (all plans): Many services require prior authorization in order to be covered. For example, if you are an Added Choice member, most Tier 2 and Tier 3 non-emergency care and procedures provided in a hospital, another care facility, or your home, except for maternity care, must be authorized at least 72 hours in advance. See your *EOC* or contact Membership Services to learn which services require prior authorization.

Temporary enrollment identification: Please make a copy of this form. You will soon receive a membership card. Until then, present this form to Membership Services, located in most of our facilities, to receive services.

Membership Services: For assistance with obtaining services, call Membership Services at **503-813-2000** in the Portland area or **1-800-813-2000** from all other areas. For TTY, call **1-800-735-2900**. For language interpretation services, call **1-800-324-8010.**

Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly slow down the enrollment process.

By mail:
Kaiser Permanente Membership Administration
PO Box 203012
Denver, CO 80220-9012

By fax:*
1-866-311-5974

*Please limit fax submissions to one enrollment form per transmission.

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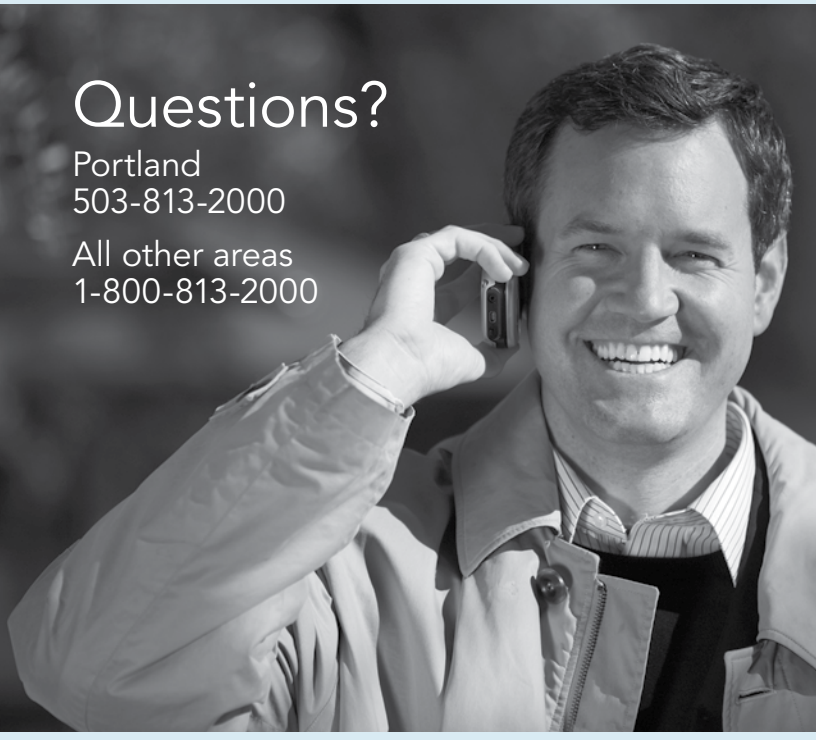
How to fill out this form

1. To be enrolled, you must live or work within the Northwest service area at least 50 percent of the time, unless you are an Added Choice® member.
2. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting it, especially effective dates, as these affect your premium.
3. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. The full-time student box should only be marked if your dependent qualifies as an overage dependent attending school. Please contact your employer about the rules for coverage of dependent students. Read section C and the back of the form. Then sign and date the form.
4. Once the form is complete, make a copy for your records. (You will soon get a membership ID card. Until then, you can use a copy of your enrollment form to identify yourself as a member at medical offices.)

All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.



Call Membership Services 8 a.m. to 6 p.m., Monday through Friday. For TTY, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010.

Get connected

I'm a new member!

Your membership ID card

You will soon be receiving a membership ID card containing your name and unique eight-digit health record number. You'll want to have this card handy when you call for an appointment, speak to an advice nurse, or come to us for care. If you don't have your ID card before your first appointment, bring a copy of your enrollment form with you.

Transfer your medical records

Call Membership Services to request a release form (phone numbers on reverse side). Then send the completed and signed form to your previous health care provider. That provider should send your records to:

Health Information Management
Regional Process Center
10220 SE Sunnyside Road
Clackamas, OR 97015

Transfer your prescriptions

Usually we can arrange a one-time refill of a prescription written by your previous doctor. Call the main pharmacy number in your medical office at least three days before you need the refill. Certain prescriptions require that you see a Participating or Select Provider before we can refill them. Once you have this prescription, you have the option of filling it online with postage-paid mail delivery.

Your online services

As a Kaiser Permanente member, you can take advantage of our convenient online services. Our most popular features include viewing lab results, requesting prescription refills, e-mailing your doctor's office, and requesting or canceling appointments.

Once you receive your membership card with your eight-digit health record number, you can get access to these features and more by registering and logging on to **kp.org**.

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