

Please select one of the following options:

\$15    \$20    \$30    \$50    \$0/\$1,500    \$0/\$2,700    \$30/\$1,000    \$30/\$1,500

# Enrollment form

Please use black ink. See instructions on page 3 before completing this form. Make a copy for your records

**A** To be completed by EMPLOYER     New group account     Existing group account

**Sacramento Assoc Realtors**  
 Company name\* \_\_\_\_\_ Group number \_\_\_\_\_ Date coverage to be effective\* \_\_\_\_\_

Enrollment unit \_\_\_\_\_ Plan selection \_\_\_\_\_ Employee classification (if applicable) \_\_\_\_\_

Employee name \_\_\_\_\_ Date of hire \_\_\_\_\_

Enrollment reason\* (Please check one.)

New group account     New hire     Open enrollment     Part-time to full-time \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Loss of coverage \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_     Other \_\_\_\_\_    Event date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**B** To be completed by EMPLOYEE

Are you now or have you ever been a member of, or received care from, Kaiser Permanente in California?     Yes     No

If so, under what medical record number (if known)? \_\_\_\_\_ Former/Maiden name? \_\_\_\_\_

Name (Last, First, MI)\* \_\_\_\_\_ Social Security number\* \_\_\_\_\_ Preferred spoken or written language (optional) \_\_\_\_\_

Home address\* \_\_\_\_\_ Apt. no. \_\_\_\_\_ City\* \_\_\_\_\_ State\* \_\_\_\_\_ ZIP code\* \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender\*  M  F    Home phone\* \_\_\_\_\_ Work phone \_\_\_\_\_

**C** Family information

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Date of birth*	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth*	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth*	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth*	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			

Will you be adding additional dependents?     Yes     No    Add any additional dependents on page 2.

**D** Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement\*:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes\*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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 and in the Certificate of Insurance.

\*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service Plans; 2) the PPO and Out-of-Area Indemnity Plans; and 3) the KPIC Dental Plans.

X \_\_\_\_\_  
 Employee signature\* (Use black ink.)    Date\*



KAISER PERMANENTE

\*Required

Check here if sending additional page(s).

# Enrollment form

If additional room for dependents is not needed, there is no need to complete or fax this page.

Employee name _____	Company name* _____	Date coverage to be effective* _____/_____/_____
Group number _____	Plan selection _____	

**E** Family information (additional dependents)

<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth* _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth* _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth* _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth* _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth* _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.* _____ Medical record no. (if known) _____
Name (Last, First, MI) _____			