KAISER PERMANENTE®

Return completed form to:
P.O. Box 34750, Seattle, WA 98124-1750

2019 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

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Work 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 (if applicable) _____

*By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

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				M ☐ F ☐		
			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.

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