California Region Kaiser Permanente Group Enrollment Form

Please print or type in black ink only. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER:		
District Name:		Hire Date (mm/dd/yyyy)
Medical Group Number:	Enrollment Unit:	Effective Enrollment Date (mm/dd/yyyy)

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#:______________________Vision Group#:________________________SISC Life Ins Group#: Employee Only____________________

A. ENROLLMENT: New group: Yes ☐ ☐ No

☐ New Hire (complete sections A, B, C, D) ☐ Full Time ☐ Part Time ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☐ Deductible Plan ☐ Other

☐ Loss of Other Coverage (complete sections A, B, C, D) ☐ Other (please specify) __________________________________

☐ Event Date (mm/dd/yyyy) ________________________________

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known)	Social Security No.		Gender
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)		☐ M ☐ F ☐ U
Home Address	City	State	ZIP
Work Phone	Home Phone	Email	
Ethnicity	Preferred Language		

C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Spouse ☐ Domestic partner ☐ Med ☐ Den ☐ Vision Spouse/domestic partner name: Gender: Male ☐ Female ☐ Undefined ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name: Gender: Male ☐ Female ☐ Undefined ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name: Gender: Male ☐ Female ☐ Undefined ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter ☐ Med ☐ Den ☐ Vision Dependent name: Gender: Male ☐ Female ☐ Undefined ☐	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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.

Signature required for all Kaiser Permanente Plans **Date**

(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the*
Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

KAISER PERMANENTE®