

Application must be **COMPLETED** in FULL, SIGNED and DATED for processing.

A. Personal Information

Please select one: New Hire Enrollment New Renewal Enrollment New COBRA Enrollment

Name of Company			Employer Phone #			Employee Job Title			Full-time Employment Date		
Sex <input type="checkbox"/> M <input type="checkbox"/> F Status <input type="checkbox"/> Married <input type="checkbox"/> Single <i>(Note: If you or any of your dependents are not enrolling, you must also complete and sign the waiver section on back.)</i> <input type="checkbox"/> Domestic Partner											
Employee Last Name						Employee Social Security Number					
Employee First Name						Date of Birth			Group Number		
Residence Address				Apt #		City		State		Zip Code	
Home Telephone ()			Email Address			Mailing Address (if different from above)					

B. Medical Benefit (select one plan only)

HMO <input type="checkbox"/> Plan 10 <input type="checkbox"/> Plan 30 <input type="checkbox"/> Plan 20/\$1,000	POS <input type="checkbox"/> POS 20/\$1,000 <input type="checkbox"/> POS 30/\$1,500	PPO <input type="checkbox"/> PPO 30/\$500 <input type="checkbox"/> PPO HSA 2200*	INDEMNITY <input type="checkbox"/> Indemnity Plan	HDHP* <input type="checkbox"/> HDHP 1900* <input type="checkbox"/> HDHP 2700*
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*HSA-Qualified High Deductible Health Plan

C. Enrollment Information (Complete this section ONLY if you are electing medical and/or dental for yourself and dependents)

	Employee	Spouse/Domestic Partner	Child/Grandchild	Child/Grandchild	Child/Grandchild
Last Name	<input type="checkbox"/> Life only				
First Name					
Relationship to Employee		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.		- -	- -	- -	- -
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		/ /	/ /	/ /	/ /
Disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

* Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

NOTE: For additional dependent enrollment, complete sections A and C on a separate application

D. Optional Benefits — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

Sections A, C & E must be completed for life coverage

DENTAL COVERAGE			
<input type="checkbox"/> DHMO 200 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> FFS 1000 <input type="checkbox"/> DHMO 250 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> FFS 1500	If you choose plans 200 or 250, you must select a dentist: Dentist: _____	ID#: _____	<input type="checkbox"/> Check if dentist chosen is current provider <input type="checkbox"/> Check if you would like a dentist assigned

LIFE INSURANCE		
Full Name of Beneficiary	Relationship of Beneficiary	Date of Birth for Beneficiary

PREMIUM ONLY PLAN (P.O.P.)
<input type="checkbox"/> I want my portion of eligible insurance premiums paid on a pre-tax basis

E. Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting this signed application, I agree and understand that the health plan chosen through the Kaiser Permanente Choice Solution program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the participating Kaiser Permanente Choice Solution health plans or their authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize the participating Kaiser Permanente Choice Solution health plans and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the employer and considered eligible by my employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
- My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and **agree** to provide *CHOICE Administrators*[®] with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the fourth page of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.

Employee Signature

Date:



Print Name

COBRA Applicants:

Please check COBRA type:
 COBRA Cal-COBRA

Indicate Qualifying Event:

- Termination of employment
- Reduction of hours
- Child no longer eligible
- Divorce/legal separation

Date of Qualifying Event

- Medicare entitlement
- Death of employee

CHOICE Administrators[®] Staff Use

New Group-employee New Hire Open Enrollment Effective Date:

F. Full Time Student Verification

If you wish to include a dependent between the ages of 19 and 24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried or not involved in a domestic partnership
- Financially dependent upon the Employee per IRS guidelines
- Enrolled as a full-time student (minimum 12 units) in a qualified college, university, vocational or secondary school

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of service/claims submitted on behalf of the dependent.

Employer Name	Employer Group Number (if available)		
Subscriber's Name	Subscriber's Social Security Number		
Student's Name	Name of School	Date Enrolled	

I certify that my above-named dependent is an unmarried student. I hereby request continuation of my child's coverage under my group Health Plan with the understanding that I will notify Kaiser Foundation Health Plan immediately if my child marries or ceases to be a full time student.

Date ____ / ____ / ____ Signature of Subscriber _____

Medical / Dental Waiver

Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.**

A. Personal Information

Name of Company	Employer Phone Number
Employee Last Name	Employee Social Security Number
Employee First Name	Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows:

- 1) **Medical for:** Myself and dependents Spouse/Domestic Partner Child(ren)/Grandchild(ren)
- 2) **Dental for:** Myself and dependents Spouse/Domestic Partner Child(ren)/Grandchild(ren)

C. Reason

Required only if employee waiving coverage

- 1) **Reason waiving Medical:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)
- 2) **Reason waiving Dental:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)

D. Signature

I understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE: 	Date
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Family Coverage Eligibility Requirements

Who can be covered?

Effective dates

Requirements that **MUST** be met:

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
New Spouse	Coverage begins on the first of month <u>following</u> date of marriage	<ul style="list-style-type: none"> Spouse must be legally married to eligible employee and the eligible employee must agree to notify CHOICE Administrators® immediately upon termination of the marriage
New Baby, Dependent Child, Grandchild†	Coverage will begin from the moment of birth through the end of the calendar month of birth, or the mother's hospitalization if she is a member, whichever is later. Premiums for continuation of coverage for the dependent will be charged beginning on the first of the month <u>following</u> the birth.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> Born to, a step-child or legal ward of, grandchild† of, or adopted by the eligible employee or the spouse of the eligible employee Dependent on the employee for at least 50% of his/her economic support Unmarried or not involved in a domestic partnership <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24</u> <p>Please note: Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.</p> <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p>Verification of eligibility will occur annually at the child's birthday</p> <p style="text-align: right;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Adopted Child, Stepchild, Non-Temporary Legal Ward	Coverage is effective on the date the member gains the right to control the dependent's healthcare, and premiums will be charged the first of the month <u>following</u> this date.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> Adopted by, stepchild of, or non-temporary legal ward of the employee Dependent on the employee for at least 50% of his/her economic support Unmarried or not involved in a domestic partnership <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24</u> <p>Please note: Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.</p> <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p>Verification of eligibility will occur annually at the child's birthday</p> <p style="text-align: right;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Domestic Partner	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a domestic partner will require a State stamped copy of the Certificate of Registered domestic partnership within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnership</p>	<p><u>The employee and domestic partner must:</u></p> <ul style="list-style-type: none"> Share a common residence Not be married under either a statutory or common law or part of another domestic partnership Be 18 years of age or older Share an intimate and committed relationship Both be mentally competent Not be related by blood to a degree of closeness that would prohibit marriage in this state Agree to notify CHOICE Administrators® immediately upon termination of the domestic partnership <p style="text-align: right;">Employee/Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
New Baby, Dependent Child, Grandchild†, Adopted Child, Stepchild, Non-Temporary Legal Ward of Domestic Partner	See Domestic Partner above	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> Born to, dependent child of, step-child of, grandchild† of, adopted by, or non-temporary legal ward of the domestic partner Dependent on the employee for at least 50% of his/her economic support Unmarried or not involved in a domestic partnership <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24</u> <p>Please note: Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.</p> <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p>Verification of eligibility will occur annually at the child's birthday</p> <p style="text-align: right;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

† Grandchild may be covered if the parent is a dependent of the covered employee and the parent is also enrolled.