KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

2020 Oregon Small Group Employee Enrollment/Change Form

Please print in black or blue ink only.

Employer section (To be completed by the employer)

Company name[1] _____

Group no.[1] _____ Effective date of coverage[1] _____ / _____ / _____

Medical subgroup no. _____ Billgroup _____

Family dental subgroup no. _____ Billgroup _____

Pediatric dental subgroup no. (18 years and younger) _____

Billgroup _____

Enrollment/change reason – complete if existing group[1] *(Please check one.)*

☐ New hire ☐ Open enrollment ☐ Part-time to full-time

☐ Newborn ☐ COBRA ☐ Change _____

☐ Loss of coverage ☐ State continuation ☐ Other _____

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

Select benefit type:[1]

☐ Medical _____ *(plan choice)*

☐ Family dental plan (19 years and older) _____ *(plan choice)*

☐ Pediatric dental plan (18 years and younger) _____ *(plan choice)*

☐ Waiving pediatric dental[2]

Name *(last, first, MI)*[1] _____

Former/maiden name *(if any)* _____

Date of birth[1] _____ / _____ / _____ Social Security no. _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Home address[1] _____ Apt. _____

City _____ State ____ ZIP _____ Email _____

Mobile phone _____ Home phone _____

Health record no. *(if any)* _____ Preferred language _____

[1]Required

[2]By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.

B Dependent information *(For additional dependents, please use our Addendum to Oregon Group Employee Enrollment/Change Form.)*

☐ Spouse ☐ Domestic partner[3]

Name *(last, first, MI)*[1] _____ Date of birth[1] ____ / ____ / ____

Social Security no. _____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Mobile phone _____ Disabled ☐ Yes ☐ No

☐ Medical ☐ Family dental (19 years and older) ☐ Pediatric dental (18 years and younger)

☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

Dependent (child) name *(last, first, MI)*[1,4] _____

Date of birth[1] ____ / ____ / ____ Social Security no. _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Mobile phone _____

Disabled ☐ Yes ☐ No

☐ Medical ☐ Family dental (19 years and older) ☐ Pediatric dental (18 years and younger)

☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

Dependent (child) name *(last, first, MI)*[1,4] _____

Date of birth[1] ____ / ____ / ____ Social Security no. _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Mobile phone _____

Disabled ☐ Yes ☐ No

☐ Medical ☐ Family dental (19 years and older) ☐ Pediatric dental (18 years and younger)

☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

☐ Check here to add additional dependents and attach the Addendum to Oregon Group Employee Enrollment/Change Form.

C Important – *Your application cannot be processed without your signature. Please read the entire form before signing.*

If you make an intentional misrepresentation of material fact through misstatement or omission, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

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 this form.

Employee signature[1] _____ Date _____ / _____ / _____

Print name: _____

[1]Required
[2]By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.
[3]A person legally recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group
[4]Eligible through the last day of the month of their 26th birthday month

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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 the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- I understand that all nonemergency services (including services provided under Tier 1 of the Added Choice® plan) are covered only when provided by or arranged by participating providers and participating facilities or select providers and select facilities.[1] (Added Choice members: See your Evidence of Coverage [EOC] for providers and facilities covered under Tier 2 and Tier 3 for nonemergency services.)

Obtaining services and prior authorization

If you are enrolling in a traditional, deductible, or high deductible (HSA-qualified) medical plan 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 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/or Tier 3 nonemergency 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 Member Services to learn which services require prior authorization.

Member Services: For assistance with obtaining services, call Member Services at 1-800-813-2000 (1-866-616-0047 for Added Choice members). For TTY, call 711. 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 delay the enrollment process.

By mail:
Kaiser Permanente Membership Administration
P.O. Box 203012
Denver, CO 80220-9012

By fax:[2]
1-866-311-5974

By email:
csc-den-roc-group@kp.org

[1]A complete definition of *select providers* and *select facilities* appears in the Evidence of Coverage.

[2]Please limit fax submissions to one enrollment form per transmission.

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How to fill out this form

1. Please print legibly in black or blue ink.

2. To be enrolled, you must live or work within the Northwest service area at least 50% of the time, unless you are an Added Choice out-of-area member.

3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting this form, especially effective dates, as these affect your premium.

4. 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. Read section C and the entire form. Then sign and date the form.

5. Once the form is complete, make a copy for your records. (You will soon get a Kaiser Permanente ID card.)

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.

Questions

Call Member Services at 1-800-813-2000 (1-866-616-0047 for Added Choice members), Monday through Friday, 8 a.m. to 6 p.m. For TTY, call 711. For language interpretation services, call 1-800-324-8010.

Get connected

Follow the simple steps on the left side of this page to enroll in your plan.

I'm a new member!

Your ID card

You will soon receive a Kaiser Permanente ID card containing your name and unique 8-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 your photo ID. Once your ID card is issued, you can access a digital copy on the Kaiser Permanente app.

Choose your doctor — and change anytime

Go to **kp.org/newmember** to browse our doctor profiles and find a doctor who matches your needs. Once you've chosen, call the New Member Welcome Desk at **1-888-491-1124** to schedule your first appointment. For TTY, call **711.**

Transfer your prescriptions

If you have prescriptions to transfer, you'll want to fill out the Transfer Your Prescriptions form at **kp.org/newmember** right away. Usually you can receive a one-time refill of a prescription written by a non-participating provider if the medication is on our formulary and your prescription allows for refills.

To order your prescriptions, call the main pharmacy number in your medical office before you need the refill. Certain prescriptions require that you see a participating provider before you can receive a refill. Once you have a prescription written by a participating provider, you can order your prescription refills at **kp.org/rxrefill**. Save additional time and money through our postage-paid Mail-Delivery Pharmacy service, available for most prescriptions.

Register at kp.org

Enjoy around-the-clock, secure access to care with online features that can save you time and money. Once you are registered, you can email your doctor's office, view most lab results, refill prescriptions, schedule routine appointments, and much more. Go to **kp.org/register** to get started. You'll need your 8-digit health record number on your ID card to register.

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