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Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

2020 Addendum to Washington Large Group Employee Enrollment/Change

This form must accompany the Washington Large Group Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Washington Large Group Employee Enrollment/Change Form.

This section to be completed by the employer.

Company name[1] ______________________ Effective date of coverage[1] ___ / ___ / ___

Group no.[1] __________ Medical subgroup no. __________ Medical billgroup __________

Dental subgroup no. __________ Dental billgroup __________

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

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) Preferred pronoun __________

B Dependent information

Dependent (child) name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ___ / ___ / ___

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

Preferred pronoun __________ Mobile phone __________ ☐ Full-time student Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy no. __________ Health record no. (if any) __________

Dependent (child) name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ___ / ___ / ___

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

Preferred pronoun __________ Mobile phone __________ ☐ Full-time student Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy no. __________ Health record no. (if any) __________

Dependent (child) name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ___ / ___ / ___

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

Preferred pronoun __________ Mobile phone __________ ☐ Full-time student Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy no. __________ Health record no. (if any) __________

Dependent (child) name *(last, first, MI)*[1,2] ______________________ Date of birth[1] ___ / ___ / ___

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

Preferred pronoun __________ Mobile phone __________ ☐ Full-time student Disabled ☐ Yes ☐ No

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No

Insurance co. __________ Policy no. __________ Health record no. (if any) __________

☐ Check here if another Addendum to Washington Large Group Employee Enrollment/Change Form is attached.

C Important

It is 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.

Employee signature[1] ______________________ Date ___ / ___ / ___

[1]Required
[2]Eligible through the last day of the month of their 26th birthday month