KAISER PERMANENTE®

2020 Addendum to Washington Small Group Employee Enrollment/Change Form

This form must accompany the Washington Small 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 Small 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. _____ Billgroup _____

Adult dental subgroup no. _____ Billgroup _____

Pediatric dental subgroup no. _____ 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 _____ Disabled ☐ Yes ☐ No

☐ Medical ☐ Adult dental (19 years and older)

☐ Pediatric dental (18 years and younger) ☐ Waiving pediatric dental[3]

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 _____ Disabled ☐ Yes ☐ No

☐ Medical ☐ Adult dental (19 years and older)

☐ Pediatric dental (18 years and younger) ☐ Waiving pediatric dental[3]

Other health insurance ☐ Yes ☐ No Insurance co. _____

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

☐ Check here if another Addendum to Washington Small 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

[3]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.