



**KAISER PERMANENTE**

MARYLAND

Kaiser Permanente Insurance Company (KPIC)

One Kaiser Plaza, Oakland, California 94612

**KAISER PERMANENTE INSURANCE COMPANY ENROLLMENT & CHANGE FORM  
PPO AND INDEMNITY PLAN OFFERINGS**

<p>Welcome to Kaiser Permanente Insurance Company (KPIC). We look forward to receiving your Enrollment and Change form. <b>If you have any question concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 before signing this form.</b></p> <p>After you have completed this form, please sign and return it to your employer's benefits office. <b><u>DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.</u></b></p> <p>If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.</p>	<p><b>Section B: Waiver of Coverage</b></p> <p>Complete this section if you voluntarily elect to waive insurance coverage offered by your employer for yourself, your spouse or domestic partner, and/or dependent children. If you are electing to waive all coverage, you only need to complete Sections A, B and sign in section G.</p>
<p><b>How to Complete this form – Please Print</b></p> <p>Use this form to enroll, waive or change (add or delete) your family members' membership status. To be a Subscriber, you must live or work within our service area and you must be an employee who meets all of your employer's eligibility guidelines. <b>If you are electing to waive all coverage, you only need to complete Sections A, B and sign in section G.</b> If you have any questions, contact your employer's benefits office.</p>	<p><b>If Making a Change Section</b></p> <p>Complete this section if you are making a change, including adding or deleting dependents or changing dependent status. If you are adding a dependent please complete sections A, C, D, E, F and G.</p>
<p><b>To Be Completed by Employer</b></p> <p>Your employer will complete this section.</p>	<p><b>Section C: Family Information</b></p> <p>Make sure your dependents meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office. If you know the Medical record number, please provide it in the requested space. To obtain a Participating Provider directory please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380, or see our Web site at <a href="http://www.kaiserpermanente.org">http://www.kaiserpermanente.org</a></p>
<p><b>Section A: Employee Information</b></p> <p>Please provide information about yourself. To indicate your choice of primary care provider, please see the line at the end of the section.</p>	<p><b>Section D: Maximum Age/Disabled Dependent</b></p> <p>Please complete this section to list any dependents that exceed your employer's' maximum limiting age requirements or are disabled. You will be requested to provide additional information to document dependents that are indicated in this section.</p>
	<p><b>Section E: Dependents residing at another PERMANENT address</b></p> <p>Please use this section to document any dependents that have another permanent address other than that of the Subscriber. You will be requested to provide additional information to document dependents that are indicated in this section. This section does not apply to dependents who are full time students living in temporary housing while attending their classes.</p>

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM

<p><b>Section F: Other Coverage Information</b></p>	<p><b>Section G: Subscriber Sign-off</b></p>
<p>Tell us if you, your spouse or domestic partner, or other family dependents are covered by other group health insurance plans. This may occur when both spouses or domestic partners are employed and have health care benefits from one or more health plan(s).</p> <p>If you or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans.</p> <p>If the Coordination of Benefits provisions apply to you, your signature on this form will permit KPIC to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners (NAIC) guidelines including , but not limited to; Medicare, Motor Vehicle Insurance (when permitted by law), Workers' Compensation, Tricare, Veterans Administration, so long as you are enrolled in the primary plan and such plan remains primary to KPIC. Your signature authorizes KPIC to release any records or information, with respect to any claim for covered services, that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380.</p>	<p>Review and sign this form. Before you sign this form, please make certain you have read all coverage materials. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card.</p> <p style="text-align: center;"><b>MISREPRESENTATION</b></p> <p>If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties. <b>You may also be liable to KPIC for the cost of health care services provided because of the false or misleading information or omission.</b></p>

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**TO BE COMPLETED BY EMPLOYER** Please print or type in black ink only.

**ENROLLMENT TYPE**

NEW  CHANGE

**EMPLOYMENT STATUS**

Active  Retired

**GROUP NO.**

**SUBGROUP NO.**

**EMPLOYEE LAST NAME**

**FIRST NAME**

**MI**

**SUFFIX**

*Check One and indicate date of event:*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> New enrollment (complete all applicable sections)         | New enrollment Effective Date (MM/DD/YYYY)         | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Open enrollment (complete all applicable sections)        | Open enrollment Effective Date (MM/DD/YYYY)        | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> COBRA (complete all applicable sections)                  | COBRA Effective Date (MM/DD/YYYY)                  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Loss of other coverage (complete all applicable sections) | Loss of Other Coverage Effective Date (MM/DD/YYYY) | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Cancel coverage (complete sections A, C and G)            | Effective Date of Cancellation (MM/DD/YYYY)        | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

**EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE**

*I hereby certify that this(these) enrollment(s) has been reviewed and meet(s) all eligibility requirements*

Printed or Typed Name/Title		
Employer Signature		
Date	Telephone	Fax





