

Please print or type in black ink only. Please see instructions on reverse *before* completing this form.
Fields with * are mandatory for enrollment.

EMPLOYER: To protect the privacy of your employee, this application must remain sealed and can only be opened by an authorized Kaiser Permanente representative.

A. TO BE COMPLETED BY EMPLOYER									
*Company or Trust Fund Name			*Purchaser Number			Enrollment Unit Number (EU)			
Company or Trust Fund Address			(____) _____ Phone Number			(____) _____ Fax Number			
Purchaser Contact			Employer ID			*Effective Date of Coverage			
*ENROLLMENT (check only one—see Enrollment Reason Table on reverse side for options)									
<input type="checkbox"/> New Hire Enrollment—Date of Hire: _____			<input type="checkbox"/> Open Enrollment						
<input type="checkbox"/> Part Time to Full Time—Date: _____			<input type="checkbox"/> Other: _____			Event Date: _____			
<input type="checkbox"/> New Purchaser									
B. EMPLOYEE/SUBSCRIBER INFORMATION									
Are you now or have you ever been a Kaiser Permanente member? <input type="checkbox"/> Yes <input type="checkbox"/> No							Height _____		
If so, what is/was your Medical Record Number? _____							Weight _____		
Have you ever received care from Kaiser Permanente within the state of California? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Under what name: _____ Maiden/Other									
*Social Security Number			*Last Name			*First Name		MI	
_____/_____/_____			*Gender: <input type="checkbox"/> M <input type="checkbox"/> F			Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			
*Date of Birth									
Preferred Language Spoken			Preferred Language Written			E-mail Address (optional)			
*Street Address					*City		*State	*ZIP Code	
(____) _____ Day Phone <input type="checkbox"/> Home <input type="checkbox"/> Work			(____) _____ Evening Phone <input type="checkbox"/> Home <input type="checkbox"/> Work			Employee ID		Employment Status: <input type="checkbox"/> Working <input type="checkbox"/> Retired	
C. LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed)									
*Last Name	*First Name	MI	*Role	*Social Security Number	*Date of Birth MM/DD/YY	*Gender	Medical Record Number if Known	Height	Weight
Spouse			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
<i>Maiden/Other:</i>									
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
<i>Relationship:</i>									
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
<i>Relationship:</i>									
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
<i>Relationship:</i>									
Dependent(s)' Address (if different from subscriber's): <input type="checkbox"/> Check here if all dependents are at the address below.									
Name(s)			Address			City		State	ZIP Code

I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs 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, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the *Evidence of Coverage*.

X _____
*Employee/Subscriber Signature *Date

D. HEALTH QUESTIONNAIRE



Important:

- You must answer every question for each family member to be enrolled. Information provided in this section will not result in a denial of coverage.
- You must sign, seal, and return this completed application to your employer.

	Subscriber	Spouse/ Domestic Partner	Dependent #1	Dependent #2	Dependent #3	Dependent #4
1. How many times have you been hospitalized in the past 12 months, except for pregnancy?	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More
2. Do you currently use, or have you in the last ten years used, tobacco on a regular basis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. Do you have any pending surgery, treatment, examination, evaluation or test for any condition that has been advised in the last three years, except for pregnancy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Have you ever been treated for, or has a doctor advised you that you have any of the following conditions? Important: Check <u>all</u> that apply or "None of the above", and continue question on next page.	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate <input type="radio"/> Skin Cancer -Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:
	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition

(continue on next page)

(cont'd from page A-2)

	Subscriber	Spouse/ Domestic Partner	Dependent #1	Dependent #2	Dependent #3	Dependent #4
4.	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other 	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other 	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other 	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other 	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other 	<input type="radio"/> Lupus/SLE <input type="radio"/> Menopause <input type="radio"/> Mental Health Condition <input type="radio"/> MS/ALS/Parkinson's/Alzheimer's <input type="radio"/> Pacemaker <input type="radio"/> Prostate Condition <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Stomach or Intestinal Problem <input type="radio"/> Stroke <input type="radio"/> Ulcer <input type="radio"/> None of the above <input type="radio"/> Other
5. Do you have <i>unexplained</i> and/or <i>undiagnosed</i> symptoms, not associated with conditions in question 4? Important: Check all that apply or "None of the above"	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above	<input type="radio"/> Fever <input type="radio"/> Swollen Glands <input type="radio"/> Chest Pain <input type="radio"/> Shortness of Breath <input type="radio"/> Abdominal or Pelvic Pain <input type="radio"/> Loss of Consciousness <input type="radio"/> Unexplained Weight Loss <input type="radio"/> Rectal Bleeding <input type="radio"/> Loss of Appetite <input type="radio"/> Dizziness <input type="radio"/> Rash <input type="radio"/> Skin Lesions <input type="radio"/> Lumps <input type="radio"/> None of the above
6. Are you regularly taking any prescription medications? If Yes, please list each medication:	<input type="radio"/> Yes <input type="radio"/> No 	<input type="radio"/> Yes <input type="radio"/> No 	<input type="radio"/> Yes <input type="radio"/> No 	<input type="radio"/> Yes <input type="radio"/> No 	<input type="radio"/> Yes <input type="radio"/> No 	<input type="radio"/> Yes <input type="radio"/> No
7. For women, are you pregnant now?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

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

Additional copies of this Health Questionnaire are available from your employer for completion by family members age 18 and older, upon request. Any missing information will affect your group's monthly rate. The information provided is confidential and will only be used for rating purposes and not for any other purpose.

Once you've answered all the questions, sign the authorization below. For your privacy, moisten edges, seal, and submit to your employer.

Please read, sign and date below

I certify that, to the best of my knowledge, the above information is true and complete.

X _____ Date

Employee/Subscriber Signature

Enrollment Application Instructions

Instructions for the Subscriber:

1. Review the **Kaiser Permanente ZIP Code Service Areas** on page 3 to make sure your home ZIP code is listed.
2. Check the box for your group's plan on the cover of this booklet and on your Temporary Membership ID, located on page 5.
3. Complete **Section B** of this *Enrollment Application*. Be sure to complete all fields to ensure we have your current information and can find any prior membership records. Please print clearly in black ink.
4. Complete **Section C** of this *Enrollment Application* for any dependents you wish to enroll. Kaiser Permanente will verify the eligibility of these dependents during the enrollment process.
5. Check with your employer to see if you are required to complete the Health Questionnaire in **Section D** of this *Enrollment Application* (required for groups with 6 – 15 enrolling employees only). If you are required to complete Section D, please follow the instructions at the top of page A-2.
6. Sign and date the bottom of page A-1 (and page A-3, if applicable).
7. Keep a copy of page A-1 of this *Enrollment Application*, to be used with your Temporary Membership ID when seeking health care services.

Instructions for the Employer:

1. Complete all fields in **Section A** to ensure we have correct account and enrollment reason information. Always indicate the appropriate enrollment reason. For "other" enrollment requests, write in the reason from the table below. Be sure to include the event date, where requested.

If this enrollment is part of your new group set-up with Kaiser Permanente, check "New Purchaser."

Enrollment Reason Table

Enrollment Reason	Event Date
Part-Time to Full-Time Status	Effective Date of Full-Time Status
Loss of Coverage	Date Coverage Was Lost
Moved into Service Area	Move Date
Rehire	Date of Rehire
Return from Layoff/Leave of Absence	Return Date
Return from Military Duty	Return Date

2. The employer is responsible for confirming all information on page A-1 of this *Enrollment Application* prior to submission. Provide each employee with a copy of page A-1, to be used with their Temporary Membership ID.
3. For groups with 6 – 15 enrolling employees only: The employees who enroll as part of your new group set-up are required to complete the Health Questionnaire in **Section D**, which will be used to determine your group's rate. To protect the privacy of your employee, this application must remain sealed and can only be opened by an authorized Kaiser Permanente representative.

NOTE: All enrollments will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.