

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

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)**

New Hire Enrollment—Date of Hire: _____ Open Enrollment
 Part Time to Full Time—Date: _____ Other: _____ Event Date: _____
 New Purchaser

B. EMPLOYEE/SUBSCRIBER INFORMATION

Are you now or have you ever been a Kaiser Permanente member? Yes 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? Yes No
 Under what name: _____
 _____ Maiden/Other _____

*Social Security Number _____ *Last Name _____ *First Name _____ MI _____
 _____ / _____ / _____ *Gender: M F Marital Status: Married Single
 *Date of Birth _____

Preferred Language Spoken _____ Preferred Language Written _____ E-mail Address (optional) _____

*Street Address _____ *City _____ *State _____ *ZIP Code _____
 (_____) _____ (_____) _____ Employment Status: _____
 Day Phone Home Work Evening Phone Home Work Employee ID _____ Working 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 Maiden/Other: _____	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Relationship:			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Relationship:			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Relationship:			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			

Dependent(s)' Address (if different from subscriber's): 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