Kaiser Permanente

California Subscriber Enrollment/Change Form

Instructions for FEHB Program Enrollees

Who should use

Federal Employees Health Benefits (FEHB) Program enrollees in Kaiser Permanente's California plans: Northern California, Fresno California, and Southern California.

When to use

Use the form to add or remove a dependent if you are currently enrolled in FEHB Self and Family coverage and adding or removing a dependent does not change your FEHB plan (Kaiser Permanente), enrollment type (Self Only, Self Plus One, Self and Family), or option (High Option, Standard Option, Basic Option). You may also use this form to change your dependent's name, your address, or other demographic information.

Do not use the form if you need to enroll, change your FEHB plan, enrollment type, or option, cancel your FEHB enrollment, or change your name or Social Security Number. Instead, contact your employing agency or retirement office and follow instructions on opm.gov.

What to complete

Complete the following sections:

B. What are the changes requested?
C. Subscriber/employee information
D. Signature
E. Dependents

Do not complete the following section:

A. Company information (your employing agency or retirement office does not need to complete; please leave blank).

Where to submit

Submit the completed form and required supporting documentation (e.g., birth certificate, marriage certificate, divorce decree, foster child certification, and other legal documents) directly to Kaiser Permanente at:

Mail	Kaiser Permanente Federal Accounts P.O. Box 23758 San Diego, CA 92193-3758
Fax	1-855-355-5334

California Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30)

Employee Number/ID

Effective date of enrollment/change* (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition for obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth* (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan Arbitration Agreement.† I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

3 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City State ZIP code

*Field required for all enrollments and changes.