California Large Commercial 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: LOS RIOS CCD

Customer ID*: 602838

Enrollment unit ID*:

Enrollment unit name/classification:

Eligibility contact phone: 916-568-3070

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*

Primary phone (mobile phone if available): - -

Mailing address (if different than home)

City

State

ZIP code

Email address

Subscriber's last name*

Subscriber's medical record (if known)

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) / /

By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information go to:

https://Healthy.kaiserpermanente.org/termsconditions

*Field required for all enrollments and changes. **Field required for all dependents age 18 yrs or older.

†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)

Email address**

Primary Phone** (mobile phone if available)

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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)

Email address**

Primary Phone** (mobile phone if available)

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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)

Email address**

Primary Phone** (mobile phone if available)

Subscriber's last name*

Subscriber's medical record (if known)

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

If you prefer, you may complete this enrollment/change transaction online by visiting **account@kp.org**.