KAISER PERMANENTE®

Small Business

EMPLOYEE/DEPENDENT CHANGE

INSTRUCTIONS

1. The employer must complete Section A.
2. The employer is responsible for confirming all information prior to submitting. Please make sure effective dates are correct as these affect health plan premiums.
3. The employee must complete Sections B through E.
4. The employee must sign and date the bottom of the form.
5. Once all sections are complete, the employee should make a copy for his or her records and give the completed form to the employer.
6. The employer should give the completed form to his or her Kaiser Permanente representative or broker.
7. This form is not an employee termination of coverage request. If you would like to terminate an employee's coverage, please use the Subscriber Termination/Transfer form.

All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Kaiser Permanente. If your address changes, then your rate may change.

A COMPANY INFORMATION

Company name			Customer ID		Enrollment unit
Street address	City		State	ZIP	County
Office phone ( ) –	Ext.	Fax ( ) –	Email		

B REQUESTED CHANGES

☐ Add dependents (complete sections C, D, and E)

Reason (see section F): Event date:

☐ Delete dependents (complete sections C, D, and E)

Reason (see section F): Event date:

☐ Employee name change (complete sections C, D, and E)

From: To: Event date:

☐ Employee address (complete section C)

☐ Employee phone (complete section C)

C EMPLOYEE INFORMATION

Name (first, MI, last)				Medical record number	
Home address	First day of residency at this address / /	City	State	ZIP	County
Home phone ( ) –	Office phone ( ) –	Ext.	Email		

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Company name (please print): _____

Employee name (please print): _____

D DEPENDENTS AFFECTED

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	

Do any of your dependents listed above live at another address? ☐ Yes ☐ No If Yes, complete the following:

Name (first, MI, last)	Address

E SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., 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*.

Employee signature **X**	Date
Employee name (please print)	Title (please print)

Note: Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2) the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.

Company name (please print): _____

Employee name (please print): _____

F CHANGE REASON

Add dependent reason	Event date
Adoption	Date of adoption
Loss of coverage	Date coverage was lost
New spouse (marriage)	Date of marriage
Moved into service area	Move date
Newborn addition	Date of birth
Open enrollment	Open enrollment effective date

Delete dependent reason	Event date
Divorce	Date of divorce
Member deceased	Date of death
Delete dependents	Dependent termination date
Open enrollment	Open enrollment effective date

G CONTACT INFORMATION

Fax:

Northern California **858-614-3344**

Southern California **858-614-3345**

For more information, please contact **800-790-4661, option 1** or email **CSC-SD-SBA@kp.org**.