KAISER PERMANENTE®

Return completed form to:
P.O. Box 34750, Seattle, WA 98124-1750

# 2018 Employee enrollment and change form

**EMPLOYER: PLEASE COMPLETE THIS SECTION.**

Effective date_____

Termination date_____

Group name_____

Group number_____

Selected health plan _____

Pay location (if applicable)_____

Original date of hire ___/___/___

Date of rehire ___/___/___

Date transferred from part time (p/t) to full time (f/t) ___/___/___

Hours worked per week _____

If retired, date of retirement ___/___/___

**Choose one:**

☐ Open enrollment ☐ Add dependent(s)

☐ New employee ☐ Remove coverage

☐ Address/name change ___ Employee ___ Dependent(s)

☐ Qualifying event _____

Date processed ___/___/___ by _____

☐ **Transfer to COBRA**

Start date ___/___/___

☐ 18 months

☐ 36 months

**EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.**

Employee name _____ Work phone (_____)_____
(Last name) (First name) (M.I.)

Resident address _____ Home phone (_____)_____
(Street) (City) (State) (ZIP)

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse (if applicable) _____

*By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

| For health plan internal use only | Check one | | Please print Last name | First name | M.I. | Social Security Number | Male/ Female | Birthdate (MM/DD/YY) | Relationship to employee |
|---|---|---|---|---|---|---|---|---|---|
| | Add | Remove | | | | | | | |
| | | | Self | | | | | | |
| | | | Spouse/domestic partner/dependent (circle one) | | | | | | |
| | | | Dependent | | | | | | |
| | | | Dependent | | | | | | |
| | | | Dependent | | | | | | |

_____
(Signature of employee) (Date signed)

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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