KAISER PERMANENTE®

12401 E. Marginal Way S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

2017 Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Effective 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 _____
(Last name) (First name) (M.I.)

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

Mailing address (if different) _____

Former name of applicant or spouse (if applicable) _____

Work phone ( ) _____

Home phone ( ) _____

Email address* _____

*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.