KAISER PERMANENTE®

Colorado Small Business Group Change Form

Please review entire form; print or type in black ink only.

EMPLOYEE LAST NAME

KAISER PERMANENTE HEALTH RECORD NUMBER

NAME OF EMPLOYER OR GROUP

GROUP NO. SUBGROUP NO. BILLGROUP UNIT DATE OF HIRE (MM/DD/YYYY) EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

DELETE DEPENDENTS (*Complete sections A, B, C, D*)

DATE (MM/DD/YYYY)

- ☐ Over age limit
- ☐ Divorce
- ☐ Deceased
- ☐ Other *(please specify)*

_____

ADD DEPENDENTS (*Complete sections A, B, C, D*)

DATE (MM/DD/YYYY)

- ☐ Birth
- ☐ Adoption*
- ☐ Marriage
- ☐ Domestic partner (*if applicable*)
- ☐ Loss of other coverage
- ☐ *Other (please specify)*

_____

OTHER CHANGES

Elect coverage

- ☐ Cobra
- ☐ State Continuation
- ☐ Name change *(also complete sections A, B, C that follow)*
  - Previous name _____
  - Current name _____
- ☐ Address (also complete sections A, C that follow)
- ☐ Telephone (also complete sections A, C that follow)

Are you or any of your dependents eligible for Medicare? If yes, please contact **1-800-632-9700** for details.

*Additional documentation may be required.

A. EMPLOYEE INFORMATION

ADD ☐ CANCEL ☐ CHANGE ☐ WAIVE ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

ADDRESS

APARTMENT NUMBER | CITY

STATE | ZIP CODE | HOME PHONE | WORK PHONE

EFFECTIVE DATE OF CHANGE (MM/DD/YYYY)

B. FAMILY INFORMATION

For additional dependents, please attach a separate sheet and put employee's name at the top.

ADD ☐ CANCEL ☐ CHANGE ☐ WAIVE ☐ SPOUSE ☐ DEPENDENT ☐ CHILD ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

EFFECTIVE DATE OF CHANGE (MM/DD/YYYY)

ADD ☐ CANCEL ☐ CHANGE ☐ WAIVE ☐ DEPENDENT ☐ CHILD ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

EFFECTIVE DATE OF CHANGE (MM/DD/YYYY)

ADD ☐ CANCEL ☐ CHANGE ☐ WAIVE ☐ DEPENDENT ☐ CHILD ☐

LAST NAME | FIRST NAME | MI | SUFFIX

SOCIAL SECURITY NUMBER | HEALTH RECORD NUMBER *(IF ANY)* | DATE OF BIRTH (MM/DD/YYYY) | MALE ☐ FEMALE ☐

EFFECTIVE DATE OF CHANGE (MM/DD/YYYY)

C. Conditions for Enrollment: I have read and agree to the terms and conditions on the reverse side of this enrollment form. Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in CRS 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

I hereby apply for Kaiser Permanente membership for myself and/or eligible family dependents listed on this form. I understand that if I/we, are accepted for membership, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

Employee/Applicant signature _____ Date _____ Employer signature _____ Date _____

D. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? YES ☐ NO ☐

Name	Insurance carrier name	Policy number	Telephone number

Is your spouse employed? YES ☐ NO ☐ Are your children employed? YES ☐ NO ☐

Does your spouse have additional insurance? YES ☐ NO ☐

Do your children have additional insurance? YES ☐ NO ☐

EMERGENCY CONTACT

Name and relationship to you	**Daytime phone number**	**Evening phone number**