Plans Underwritten by:
Kaiser Foundation Health Plan of Washington Options Inc., 320 Westlake Avenue N, Suite 100, Seattle, WA 98109
Kaiser Foundation Health Plan of Washington, 320 Westlake Avenue N, Suite 100, Seattle, WA 98109

2017/2018 Employee Benefits Enrollment/Change Form

Effective Date _____ **HR Initials** _____

TO BE COMPLETED BY EMPLOYER: ☐ **New Employee** ☐ **Open Enrollment** ☐ **Change**

Date of Hire _____ Dept/Loc Code _____ Monthly Salary _____

Please check the appropriate box**:** ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4

Marital Status: ☐ Single ☐ Single w/ Children ☐ Married ☐ Married w/ Children
☐ State-Registered Domestic Partner ☐ State-Registered Domestic Partner w/ Children

For Currently Enrolled Employees, Provide Qualifying Event _____

Date of Qualifying Event _____

GENERAL INFORMATION

Name of Employee _____ Soc. Sec. # _____ Date of Birth _____
Last, First, Middle Initial

Employee Residence _____ _____ _____ _____
Street or P.O. Box City State Zip

Home Phone # (____) _____ Work Phone # (____) _____ Weekly Hours Worked _____

MEDICAL PLAN ☐ Kaiser Permanente Access PPO (6262600) ☐ Kaiser Permanente Bronze HMO (4058100)
☐ Kaiser Permanente HSA HMO Individual (1551300) ☐ Kaiser Permanente HSA HMO Family (1551400)
☐ Declined, complete waiver form

ENROLLMENT INFORMATION Please list yourself and all dependents to be added or deleted.
Dependent children are covered through age 25.

Coverage Elected *Mark with an 'X'*

Add	Delete	Name (Last, First, Middle Initial)	Social Security #	Sex	Birthdate	Relationship	Medical
		EMPLOYEE	See Above		See Above	SELF	
☐	☐						☐
☐	☐						☐
☐	☐						☐
☐	☐						☐

Deduct my Medical, Dental and Vision Premium Pre-Tax, if applicable. ☐ Yes ☐ No

I understand that once I make an initial election to have my health insurance premiums paid for using pre-tax dollars, **that election will remain in force from plan year to plan year**. Each plan year I will be notified in writing of the upcoming renewal of the plan and if I want to change my election, I must complete a new enrollment form. Otherwise, my election will remain as previously elected.

REQUIRED MEDICAL ENROLLMENT INFORMATION Will you or any one on this application applying for coverage continue medical coverage through a different carrier? ☐ **Yes** (complete below) ☐ **No** (skip to "B")

A. Enrollee Name*	Medical[1] Carrier	City/State	Date Coverage Began

[1] i.e. Medicare, Premera, Regence, etc.

*If you are enrolling more than 4 dependents ask your employer for an Enrollment Form Addendum.

B. If the dependent child(ren) being enrolled is/are covered under another medical plan and the natural parents are divorced or separated, State regulations require the carrier to ask the following:

Name of parent with custody, (if parents have dual custody, indicate):_____

If divorced, did the court establish financial responsibility for the child(ren)'s health care? ☐ Yes ☐ No

If yes, please specify the name and address of the parent with responsibility: _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby apply for the employer-paid benefits and other benefits as elected on this enrollment form and the terms contained therein. I certify that if this application includes persons in addition to myself, that such persons are my lawful and/or eligible dependents. Legal documentation is attached for court-appointed wards.

I agree that falsification of any statement in this application which materially affects the acceptance of this contract may bar the right to services under the contract. I hereby authorize any of the carriers underwriting benefits, or their agents, to examine any physician's, hospital's, or insurance carrier's records concerning me or my dependents listed hereon. I understand that 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.

I authorize the Social Security Administration to furnish any insurance company, health service contractor or Health Maintenance Organization underwriting Medical and/or Dental benefits through a contract with my employer, medical or other information acquired by it under Title XVII Program (Medicare) to the extent necessary to process any claim under the agreement in effect with the aforementioned benefit underwriters should I or any of my dependents become eligible.

I authorize deductions from my earnings to cover my contribution, if required towards the cost of my benefits.

➔ X_____ _____

Please sign your name. Do not print. Date Signed

Note: Please sign and date even if no dependent or voluntary plan deductions.

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Kaiser Permanente Civil Rights Coordinator.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Kaiser Permanente Civil Rights Coordinator, Kaiser Foundation Health Plan of Washington Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@kp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ ប្រយ័ត្ន៖** បើសិនអ្នកនិយាយខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.