Plans Underwritten by:
Kaiser Foundation Health Plan of Washington Options Inc., 601 Union St, Suite 3100, Seattle, WA 98101-1374
Kaiser Foundation Health Plan of Washington, 601 Union St, Suite 3100, Seattle, WA 98101-1374

2018/2019 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 _____

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

Eligible for Employer Paid Life? ☐ Yes ☐ No Eligible for Employer Paid LTD? ☐ Yes ☐ No

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 Bronze HMO (4058100) ☐ Kaiser Permanente Access PPO (6262600)
☐ 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.

Add	Delete	Name (Last, First, Middle Initial)	Social Security #	Sex	Birthdate	Relationship	Coverage Elected *Mark with an 'X'* 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 producers, 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, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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 Kaiser Permanente Member Services.

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, sex, sexual orientation, or gender identity, you can file a grievance by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge.

Kaiser Permanente Member Services

Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Fax: 206-901-6205 or toll-free 1-888-874-1765
Address: PO Box 34593, Seattle, WA 98124-1593
Email: csforms@ghc.org

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

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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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).

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)**៖ បរយ័ត៖** បើសិនអកនិយាខែរ, សេជំនួយែជក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូរស័ព 1-888-901-4636 (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 ኣማርኛ 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.