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

2020/2021 Employee Benefits Enrollment/Change Form

Effective Date _____ **HR Initials** _____

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

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

Marital Status: ☐ Single ☐ Single w/ Children ☐ Married ☐ Married w/ Children
☐ State-Registered Domestic Partner ☐ State-Registered Domestic Partner w/ Children
Washington State-Registered Domestic Partners are treated the same as a Spouse

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 $3000 (4058100) ☐ Kaiser Permanente Access PPO $100 (6262600)
☐ Kaiser Permanente HSA HMO $2500 Ind (1551300) ☐ Kaiser Permanente HSA HMO Fam $5000 (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'* Med
		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.