KAISER PERMANENTE®

Return completed form to:
P.O. Box 34750, Seattle, WA 98124-1750

2019 Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Effective date_____

Termination 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 _____ Work phone (_____)_____
(Last name) (First name) (M.I.)

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

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse (if applicable) _____

*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)

Submit Form

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.

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