

Hawaii Region Group Enrollment/Change Form

Please see instructions on page 3 on completing this form; print or type in black ink only. Be sure to staple pages 1 and 2 together, also make a copy for yourself and your employer. Use your copy as a temporary ID after the effective date.

TO BE COMPLETED BY EMPLOYER

COMPANY NAME

GROUP NO.

SUBGROUP NO.

BILLGROUP UNIT

DATE OF HIRE (MM/DD/YYYY)

EFFECTIVE DATE (MM/DD/YYYY)

NEW ENROLLMENT Check one:

 New hire (complete sections A, B, C, D)

 Open enrollment (complete sections A, B, C, D)

 Loss of other coverage (complete sections A, B, C, D)

 COBRA (complete sections A, B, D)

 Cancel all coverage (empl. and family) (complete section A)

 Qualifying event
 Other (please specify) _____

 Date of event
PLAN Check one:

 HMO

 Added Choice

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:
DELETE DEPENDENTS (Complete sections A, B, C, D)

DATE

 Over age limit

 Divorce

 Deceased

 Other (please specify) _____

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

DATE

 Birth

 Adoption*

 Marriage*

 Loss of other coverage

 Other (please specify) _____

OTHER CHANGES (Complete sections A, B, D)

 Name change

 Address (complete sections A, D)

Previous name _____

 Telephone (complete sections A, D)

Current name _____

A. EMPLOYEE INFORMATION

LAST NAME

FIRST NAME

MI

SUFFIX

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

ADDRESS

APARTMENT NUMBER

CITY

STATE

ZIP CODE

HOME PHONE

WORK PHONE

PREFERRED SPOKEN OR WRITTEN LANGUAGE (OPTIONAL)

ETHNICITY (OPTIONAL)



B. FAMILY INFORMATION

EMPLOYEE LAST NAME

□□□□□□□□□□□□□□□□

SOCIAL SECURITY NUMBER

□□□-□□□-□□□□

ADD DELETE

MEDICAL DENTAL

SPOUSE DOMESTIC PARTNER

LAST NAME

□□□□□□□□□□□□□□□□

FIRST NAME

□□□□□□□□□□□□□□

MI SUFFIX

□ □□

SOCIAL SECURITY NUMBER

□□□□-□□□□-□□□□□□

MEDICAL RECORD NUMBER (IF ANY)

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DATE OF BIRTH (MM/DD/YYYY)

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MALE FEMALE

ADD DELETE

MEDICAL DENTAL

DEPENDENT CHILD OTHER

LAST NAME

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FIRST NAME

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MI SUFFIX

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SOCIAL SECURITY NUMBER

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MEDICAL RECORD NUMBER (IF ANY)

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DATE OF BIRTH (MM/DD/YYYY)

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MALE FEMALE

ADD DELETE

MEDICAL DENTAL

DEPENDENT CHILD OTHER

LAST NAME

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FIRST NAME

□□□□□□□□□□□□□□

MI SUFFIX

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SOCIAL SECURITY NUMBER

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MEDICAL RECORD NUMBER (IF ANY)

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DATE OF BIRTH (MM/DD/YYYY)

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MALE FEMALE

Do any of your dependents above live at another address? YES NO If yes, please complete the following:

Name(s) (Last, First, MI)	Address

Are any of your listed dependents over the maximum age? If yes, please complete the following:

Name(s) (Last, First, MI)	Disabled*	Full-time student	Name of college, university, or trade school
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	

C. 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

D. Important: Your application cannot be processed without your signature. Please read the reverse side before signing.

I apply for Health Plan membership for the persons listed and agree that we shall abide by the *Group Medical and Hospital Service Agreement, Benefit Schedule, Riders, and Contract Face Sheet*, including provisions which require that:

1. Except for certain situations outlined in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
3. I had an opportunity to read the privacy information on the cover sheet of this form.
4. I certify that I am at least 18 years of age and have the legal authority to contract for medical insurance for the person(s) listed on the enrollment form.

Employee/Applicant signature	Date	Employer signature	Date
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*Additional documentation may be required.



KAISER PERMANENTE GROUP ENROLLMENT/CHANGE FORM INSTRUCTIONS**USE THIS FORM TO:**

1. Enroll employee, spouse, and dependents.
2. Add dependents to the plan.
3. Delete employee and dependents from the plan.
4. Change name for employee and dependents.
5. Change address for employee.

DEFINITIONS OF TERMS:

1. Spouse—Subscriber's legally married spouse. State of Hawaii does not recognize common law marriage.
2. Dependents—Legal dependents and unmarried dependent children up to age 19, or as specified by your group's contract.
3. Address—Subscriber and eligible dependents may enroll if living in the Hawaii service area of Oahu, Maui, and Hawaii at the time of enrollment. After enrollment, members must continue to live in the Hawaii service area in order to remain a member.

TO COMPLETE FORM:

1. Please print, use a ballpoint pen, and press firmly.
2. When adding or deleting dependents, always include the employee/subscriber's name.
3. If dependent's address is different than employee's, please indicate on section B.
4. If you need to use another enrollment form, remember to include the subscriber's name on all forms.
5. This form must be signed by subscriber/responsible party.
6. Please refer to employer for correct group number, subgroup number, and billgroup unit (required).
7. Return entire enrollment form to employer.
8. Employer, give pink copy to subscriber to use as a temporary ID card after you sign the enrollment form.
9. Employer, return the remaining pages of the enrollment form to address below:

Kaiser Permanente
Membership Administration
P.O. Box 203011
Denver, CO 80220-9011

PRIVACY INFORMATION

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes such as quality assessment and improvement, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our "Notice of Privacy Practices" which is on our Web site at kp.org, in our medical offices, or by calling our Customer Service Center. If you have questions or concerns about our privacy practices, please contact our Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).