# 2019 Oregon Large Group Employee Enrollment/Change Form

*Please print in black or blue ink only.*

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

**This section must be filled out in full by the employer. Please print or type legibly.**

Company name[1] _____ Effective date of coverage[1] ___ / ___ / ___

Medical group no.[1] _____ Medical subgroup no.[1] _____ Billgroup[1] _____

Dental group no. _____ Dental subgroup no. _____ Billgroup _____

**Enrollment/change reason — complete if existing group[1]** *(Please check one.)* Event date ___ / ___ / ___

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part-time to full-time ☐ Change _____

☐ Open enrollment ☐ COBRA ☐ State continuation ☐ Other/qualifying event _____

## A Employee information (Employee completes sections A, B, and C.)

**Select benefit type:** ☐ Medical _____ (plan choice) ☐ Dental _____ (plan choice)

Name *(last, first, MI)*[1] _____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Former/maiden name *(if any)* _____ Date of birth[1] ___ / ___ / ___ Social Security no.[1] _____

Home address[1] _____ Apt. _____

City _____ State ____ ZIP _____ Email _____

Home phone[1] _____ Work phone _____

Health record no. *(if any)* _____ Preferred language _____ Ethnicity _____

## B Dependent information (For additional dependents, please use our Addendum to Oregon Group Employee Enrollment/Change Form. If this is for additions of dependents, please include all dependents whom you want to remain on the plan after the change effective date.)

☐ Spouse ☐ Domestic partner[2] Name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

Dependent (child) name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

Dependent (child) name *(last, first, MI)* _____ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] _____

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. *(if any)* _____

☐ Check here to add additional dependents and attach the Addendum to Oregon Group Employee Enrollment/Change Form. Include employee name and Social Security number on form.

## C Important – Your application cannot be processed without your signature. Please read the entire form before signing.

If you make an intentional misrepresentation of material fact through misstatement or omission, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits. I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on this form.

Employee signature[1] _____ Date ___ / ___ / ___

[1] *Required*

[2] *A person legally recognized as your domestic partner in a valid Declaration of Oregon Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.*

## Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.
- For traditional, deductible, or high deductible (HSA-qualified) medical plans — I understand that all nonemergency services are covered only when provided by or arranged by participating providers and participating facilities or select providers and select facilities.[1]

## Obtaining services and prior authorization

**If you are enrolling in a traditional, deductible, or high deductible (HSA-qualified) medical plan or dental plan:**

All services must be provided, prescribed, or directed by participating providers or Permanente Dental Associates dentists, except for qualifying emergency and urgent care (outside our service area) or authorized referrals.

**If you are enrolling in Added Choice®:** All Tier 1 services must be provided, prescribed, or directed by select providers, except emergency care or authorized referrals.

**If you are enrolling in PPO Plus®:** All Tier 1 services must be provided or prescribed by PPO providers and PPO facilities, except emergency care. See your *Evidence of Coverage (EOC)* for providers and facilities covered under Tier 2 for nonemergency services.

**Prior authorization (all plans):** Many services require prior authorization in order to be covered. For example, if you are an Added Choice member, most Tier 2 and/or Tier 3 nonemergency care and procedures provided in a hospital, another care facility, or your home, except for maternity care, must be authorized at least 72 hours in advance. See your *EOC* or contact Member Services to learn which services require prior authorization.

**Member Services:** For assistance with obtaining services, call Member Services at 1-800-813-2000 (1-866-616-0047 for Added Choice and PPO Plus members). For TTY, call 711. For language interpretation services, call 1-800-324-8010.

## Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly delay the enrollment process.

**By mail:**
Kaiser Permanente Membership Administration
P.O. Box 203012
Denver, CO 80220-9012

**By fax:**[2]
1-866-311-5974

**By email:**
csc-den-roc-group@kp.org

[1]A complete definition of select providers and select facilities appears in the *Evidence of Coverage*.
[2]Please limit fax submissions to one enrollment form per transmission.

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## How to fill out this form

1. Please print legibly in black or blue ink.
2. To be enrolled, you must live or work within the Northwest service area at least 50 percent of the time, unless you are an Added Choice or PPO Plus member. To enroll in PPO Plus, you must live and physically work outside Clark and Cowlitz counties for an employer who is located in one of these two counties.
3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting this form, especially effective dates, as these affect your premium.
4. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. Read section C and the entire form. Then sign and date the form.
5. If this is a change in enrollment such as adding a dependent, complete all sections and include all dependents to be covered as of the effective date of the change.
6. Once the form is complete, make a copy for your records. (You will soon get a membership ID card. Until then, you can use a copy of your enrollment form to identify yourself as a member at our facilities.)

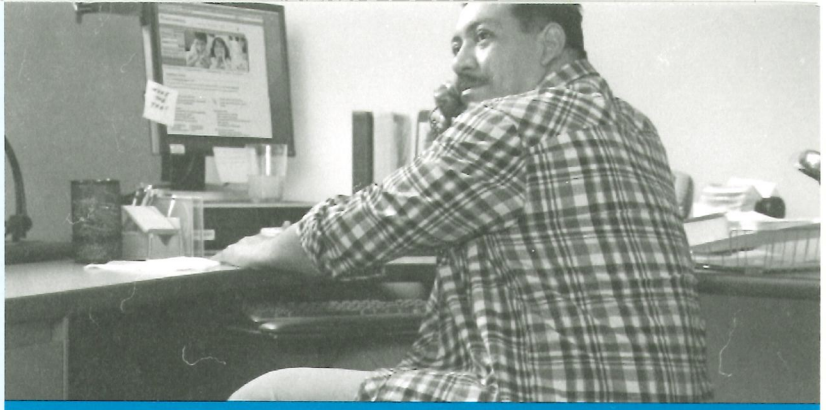
*All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.*

Call Member Services Monday through Friday, 8 a.m. to 6 p.m. For TTY, call 711. For language interpretation services, call 1-800-324-8010.

# Member Services

1-800-813-2000

FOLGENRL0119



# Get connected

Follow the simple steps on the left side of this page to enroll in your plan.

## I'm a new member!

### Your membership ID card

You will soon receive a membership ID card containing your name and unique eight-digit health record number. You'll want to have this card handy when you call for an appointment, speak to an advice nurse, or come to us for care. If you don't have your ID card before your first appointment, bring a copy of your enrollment form with you.

### Transfer your medical records

Transferring your medical records is easy. Download and submit the authorization form at **kp.org/newmember**, and we will take care of the rest. You can also contact Member Services at **1-800-813-2000** for a form.

### Transfer your prescriptions

If you have prescriptions to transfer, you'll want to fill out the Transfer Your Prescriptions form at **kp.org/newmember** right away. Usually you can receive a one-time refill of a prescription written by a non-participating provider if the medication is on our formulary and your prescription allows for refills.

To order your prescriptions, call the main pharmacy number in your medical office before you need the refill. Certain prescriptions require that you see a participating provider before you can receive a refill. Once you have a prescription written by a participating provider, you can order your prescription refills at **kp.org/rxrefill**. Save additional time and money through our postage-paid Mail-Delivery Pharmacy service, available for most prescriptions.

### Register at kp.org

Enjoy around-the-clock, secure access to care with online features that can save you time and money. Once you are registered, you can email your doctor's office, view most lab results, refill prescriptions, schedule routine appointments, and much more. Go to **kp.org/register** to get started. You'll need your eight-digit health record number on your membership ID card to register.

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