

## Cal-COBRA Enrollment Form

Please print or type in black or dark blue ink only. Please read the "Cal-COBRA Information Sheet" before submitting this form. Retain a copy for your records and to use as a temporary ID card if you are a new Kaiser Permanente member.

| Employer Group Coverage Information  |  |  |   |                            |                                |                               |   |
|--|--|--|---|----------------------------|--------------------------------|-------------------------------|---|
| Please complete the following information so we will know about your employer's account with us. The employer from which you originally obtained COBRA should be used regardless of your current employer/employment status.   | Purchaser/Enrollment Unit Number (Your employer can provide this to you.) Employer |  |   |                            |                                |                               |   |
|  | Employee name (Last/First/MI)  |  |   |                            |                                |                               |   |
|  | Date of birth  Employee medical record number (printed on your ID card)            |  |   |                            |                                |                               |   |
|  | During this employment was Kaiser Permanente your group coverage?                  |  |   |                            |                                |                               |   |
| Enrollment Information   |  |  |   |                            |                                |                               |   |
| Reason for Cal-COBRA Enrollment  ☐ Termination of Employment: Last Date of Group Coverage: MO  |  |  |   |                            |                                |                               |   |
| Subscriber and Family Information  |  |  |   |                            |                                |                               |   |
| Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage or COBRA coverage may be enrolled as part of your Cal-COBRA account. (Attach additional sheet, if needed.) |  |  |   |                            |                                |                               |   |
| Subscriber Information   |  |  |   |                            |                                |                               |   |
| Name: (Last/First/MI)  |  | Social Secu                            | Social Security number                          |                            | rth Gender<br>(circle o<br>M F | ne)                           | al record number                                      |
| Address: (Street/City/State/ZIP)   |  |  |   |                            |                                |                               |   |
| Day phone number Evening phone num   |  | umber                                  | per Email address (for enrollment purpose only) |                            | pose only)                     |                               |   |
| Family Information   | '  |  |   | ·                          |                                |                               |   |
| Spouse or domestic Name: (Last/First/MI)   |  | Role                                   | Social Secu                                     | rity number                | Date of birth                  | Gender<br>(circle one)        | Medical record number                                 |
| partner<br>(if eligible)   |  | O Spouse O Domestic partner            |   |                            |                                | M F                           |   |
| Dependent  |  | O Child O Student                      |   |                            |                                | M F                           |   |
| Dependent  |  | O Child O Student                      |   |                            |                                | M F                           |   |
| on behalf of myself and my family and other terms and conditions of t  | members listed on this Form,<br>he Group health plan docume                        | if any, agree to<br>ents, including th | be bound by<br>ne Evidence o                    | the benefit<br>of Coverage | ts, co-payments                | , deductible<br>ed the stater | es, exclusions, limitations<br>ments on this form and |

they are true and correct. The Health Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Form.

Note: Use of binding arbitration does not apply to Kaiser Permanente Insurance Company or Out-of-Network service disputes

Kaiser Permanente Arbitration Agreement: I understand that (except for small claims court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature Date

## Guidelines for completing this form

Be sure to read the enclosed Information Sheet as well as your Notice of Right to Elect Cal-COBRA Continuation Coverage and Important Information About Your Cal-COBRA Continuation Coverage Rights. If you did not receive any of these documents, please contact your employer or our Member Service Call Center at **1-800-464-4000**.

- 1. Complete all applicable fields on the form. Use only dark blue or black ink. Please print clearly.
- 2. Complete and sign this enrollment form. The subscriber (employee) must sign the form; or, in the case of spouse or dependent making their own individual election, such individual must sign the form. With respect to an individual under the age of 18, the parent or legal guardian must sign the form. Include information on all dependents to be covered.
- 3. The subscriber (employee) on the group coverage account is not required to be enrolled in the Cal-COBRA account. If the employee does not enroll in Cal-COBRA, please specify who the new subscriber on the account should be in the "Subscriber Enrollment Information" section of the form.
- 4. To be eligible, a spouse or dependent children must have been covered under your group plan. The only exception to this is if you are transferring your existing Cal-COBRA account to Kaiser Permanente, are making a new election at Open Enrollment, or are enrolling new dependents under the special enrollment provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996) during open enrollment.
- 5. Kaiser Permanente will provide you with rate information on Cal-COBRA accounts.
- 6. Renewal plan benefit information should be provided by the employer.

- 7. Do not submit payment with this form. Once Kaiser Permanente has enrolled your application, you will begin receiving monthly invoices.
- 8. If enrolling in Cal-COBRA, mail or fax (not both) the completed form to the address provided below.
- Be sure to include the Medical Record Numbers of any members who are, or have ever been, Kaiser Permanente members. It is very important that members retain their Medical Record Numbers.
- 10. Only new members will receive an ID card. Existing members **will not** receive new cards. Please continue to use your existing card.
- 11. If you are transferring your existing Cal-COBRA account from another carrier to Kaiser Permanente during Open Enrollment, be sure to tell us the original reason for your Cal-COBRA coverage, and identify your other carrier's name and your original start date of coverage.

Use the information below to submit your Cal-COBRA application for enrollment.

Mailing Address:

Kaiser Permanente PO Box 23127 San Diego, CA 92193

Fax Numbers:

Southern California Accounts: 1-858-614-3345 Northern California Accounts: 1-858-614-3344

> 012 AMT 01-3006/C (09/2002) 6906-0002-01-r03

## Cal-COBRA Enrollment Form

Please read instructions and complete form to request enrollment in a Kaiser Permanente Cal-COBRA account.

