KAISER PERMANENTE®

Small Business

EMPLOYEE/DEPENDENT CHANGE

INSTRUCTIONS

1. The employer must complete Section 1.
2. The employer is responsible for confirming all information prior to submitting. Please make sure effective dates are correct as these affect health plan premiums.
3. The employee must complete Sections 2 through 5.
4. The employee must sign and date the bottom of the form.
5. Once all sections are complete, the employee should make a copy for his or her records and give the completed form to the employer.
6. The employer should give the completed form to his or her broker or the California Service Center (CSC) by fax:
   Northern California **858-614-3344**
   Southern California **858-614-3345**
   or email: **CSC-SD-SBA@kp.org**.
7. This form is not an employee termination of coverage request. If you would like to terminate an employee's coverage, please use the Subscriber Termination/Transfer form available at **kp.org/smallbusinessforms/ca**.

All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Kaiser Permanente. If your address changes, then your rate may change.

1 COMPANY INFORMATION

Company name			Customer ID	Enrollment unit
Office phone ( ) –	Ext.	Fax ( ) –	Email	

2 REQUESTED CHANGES

☐ Add dependents (complete Sections 3, 4, and 5)

Reason (see Section 6): Effective date:

☐ Delete dependents (complete Sections 3, 4, and 5)

Reason (see Section 6): Effective date:

☐ Employee name change (complete Sections 3, 4, and 5)

From: To: Effective date:

☐ Employee address (complete Section 3)

☐ Employee phone (complete Section 3)

☐ Employee Social Security number (complete Section 3)

3 EMPLOYEE INFORMATION

Name (first, MI, last)			Social Security number	Medical record number		
Home address	First day of residency at this address / /		City	State	ZIP	County
Day phone ( ) –	Evening phone ( ) –	Ext.	Email			

Company name (please print): _____

Employee name (please print): _____

4 DEPENDENTS AFFECTED

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (first, MI, last)		Medical record number (if known)	

Do any of your dependents listed above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (first, MI, last)	Address

5 SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our 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*.

Employee signature	Date
X	
Employee name (please print)	Title (please print)

Note: Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2) the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.

Company name (please print): _____

Employee name (please print): _____

6 CHANGE REASON

Add dependent reason (circle one)

Adoption	Effective date
Loss of coverage	Effective date
New spouse (marriage)	Effective date
Moved into service area	Effective date
Newborn addition	Effective date
Open enrollment	Effective date

Delete dependent reason (circle one)

Divorce	Effective date
Member deceased	Effective date
Delete dependents	Effective date
Open enrollment	Effective date

7 CONTACT INFORMATION

Fax:

Northern California **858-614-3344**

Southern California **858-614-3345**

For more information, please contact **800-790-4661, option 1** or email **CSC-SD-SBA@kp.org**.