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 Small Business Services California Service Center (CSC) by fax:
   Northern California **858-614-3344**
   Southern California **858-614-3345**
   or email: **CSC-SD-SBA@kp.org**.
7. 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/customer and Kaiser Permanente. If your address changes, then your rate may change.

1 COMPANY INFORMATION

Company name			Customer ID
Phone ( ) –	Ext.	Fax ( ) –	Email

2 REQUESTED CHANGES

Reasons to add dependent (list 1 only): adoption, loss of coverage, new spouse (marriage), moved into service area, newborn addition, open enrollment
Reasons to delete dependent (list 1 only): divorce, member deceased, open enrollment, other

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

Reason: Effective date: / /

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

Reason: Effective date: / /

☐ Employee name change (complete Sections 3 and 5)

From: To: Effective date: / /

(Complete Sections 3 and 5 if any of the following are selected)

☐ Employee address ☐ Employee phone ☐ Employee Social Security number

3 EMPLOYEE INFORMATION

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

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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	
City	State	ZIP	County

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

Note: Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.

6 CONTACT INFORMATION

Fax:

Northern California **858-614-3344**
Southern California **858-614-3345**

For more information, please contact our Small Business Services California Service Center at **800-790-4661, option 1** or email **CSC-SD-SBA@kp.org**.