Employee enrollment and change form

12401 E. Marginal Way S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

EMPLOYEE: PLEASE COMPLETE THIS SECTION.

Group name: Lake Washington District

Choose one: Kaiser Foundation Health Plan of Washington

- ☐ Core/HMO A #00385
- ☐ Core/HMO B #16641

Kaiser Foundation Health Plan of Washington Options, Inc.

- ☐ Access PPO Plan 1, Group #64498
- ☐ Access PPO Plan 2, Group #64497
- ☐ Access PPO Plan 3, Group #64496
- ☐ Access PPO Plan 4, Group #64495
- ☐ Access PPO QHDHP, Group #64499/#64500

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Coverage effective date ____/____/____

Original date of hire ____/____/____

Date of rehire ____/____/____

Date transferred from part time (p/t) to full time (f/t) ____/____/____

Hours worked per week ____________

If retired, date of retirement ____/____/____

Choose one:

- ☐ Open enrollment
- ☐ New employee
- ☐ Address/name change
- ☐ Add dependent(s)
- ☐ Remove coverage
  - ___ Subscriber
  - ___ Dependent(s)

☐ Qualifying event ________________

Date processed ____/____/____ by _____

☐ **Transfer to COBRA**

Start date____/____/____

- ☐ 18 months
- ☐ 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name ______________________________________
(Last name) (First name) (M.I.)

Resident address ______________________________________
(Street) (City) (State) (ZIP)

Mailing address (if different) ______________________________________

Former name of applicant or spouse (if applicable) ______________________________________

Selected health plan: ______________________________________

Work phone ( ) ____________________

Home phone ( ) ____________________

Email address*____________________

*By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

For health plan internal use only	Check one		Please print Last name	First name	M.I.	Social Security number	Male/ Female	Birthdate (MM/DD/YY)	Relationship to employee
	Add	Remove							
			Self						
			Spouse/domestic partner/dependent (circle one)						
			Dependent						
			Dependent						
			Dependent						

____
(Signature of employee) **(Date signed)**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington, registered in Washington state, or Kaiser Foundation Health Plan of Washington Options, Inc., registered in Washington and Idaho.