KAISER PERMANENTE®

Account Change Form

Please print or type in black or dark blue ink only. Please see instructions on reverse *before* completing this form.
Retain last copy for your records and use as a temporary ID.

A. TO BE COMPLETED BY EMPLOYER

Company Name or Trust Fund Name _____ Purchaser Number _____ – Enrollment Unit Number (EU) _____

Purchaser Contact _____ (_____) Phone Number _____ (_____) Fax Number _____

B. REQUESTED CHANGE(S)

❑ Address Change (Complete Section C)
❑ Name Change (Complete Sections C and D)
❑ Add Dependent (Complete Sections C and E)
❑ Delete Dependent (Complete Sections C and E)

C. EMPLOYEE/SUBSCRIBER INFORMATION (Please complete all fields)

❑ Check here if new address

Last Name _____ First Name _____ MI _____ Medical Record Number _____

Street Address _____ City _____ State _____ ZIP Code _____

Social Security Number _____–_____–_____ (_____) Day Phone _____ (_____) Evening Phone _____

D. NAME CHANGE

From: Last Name _____ First Name _____ MI _____ To: Last Name _____ First Name _____ MI _____

E. LIST FAMILY MEMBERS TO BE ENROLLED/DELETED (Please attach additional sheet, if adding more than three dependents.)

Have any dependents ever been Kaiser Permanente members? If so, please indicate their Medical Record Number in the field below.

Spouse ❑ Add ❑ Delete

Medical Record No. _____ Social Security No. _____ – _____ Maiden/Other Name _____

Last Name _____ First Name _____ MI _____ ❑ Male ❑ Female ❑ Spouse ❑ Domestic Partner

Reason for Add/Delete (See back of form) _____ Date of Birth ___/___/___ Event Date ___/___/___ Effective Date ___/___/___

Dependent 1 ❑ Add ❑ Delete

Medical Record No. _____ Social Security No. _____ – _____ ❑ Child ❑ Student

Last Name _____ First Name _____ MI _____ ❑ Male ❑ Female Relationship _____

Reason for Add/Delete (See back of form) _____ Date of Birth ___/___/___ Event Date ___/___/___ Effective Date ___/___/___

Dependent 2 ❑ Add ❑ Delete

Medical Record No. _____ Social Security No. _____ – _____ ❑ Child ❑ Student

Last Name _____ First Name _____ MI _____ ❑ Male ❑ Female Relationship _____

Reason for Add/Delete (See back of form) _____ Date of Birth ___/___/___ Event Date ___/___/___ Effective Date ___/___/___

Dependent 3 ❑ Add ❑ Delete

Medical Record No. _____ Social Security No. _____ – _____ ❑ Child ❑ Student

Last Name _____ First Name _____ MI _____ ❑ Male ❑ Female Relationship _____

Reason for Add/Delete (See back of form) _____ Date of Birth ___/___/___ Event Date ___/___/___ Effective Date ___/___/___

Dependent(s)' Address (if different from subscriber's): ❑ Check here if all dependents are at the address below.

Name(s)	Address	City	State	ZIP Code

I understand that, except for Small Claims Court cases and claims subject to a Medicare appeals procedure, 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 arbitration provision is contained in the *Evidence of Coverage*.

Subscriber Signature (Required for all changes) _____ **Date** _____

TOP COPY–To Kaiser Permanente (CSC) **MIDDLE COPY**–To be retained by purchaser **BOTTOM COPY–To be retained by subscriber and used as temporary ID**

Account Change Form Instructions

General instructions:

1. Please print firmly and legibly in black or dark blue ink.
2. To be enrolled, you must reside within the ZIP codes listed on the enclosed sheet.
3. The employer must complete Section A.
4. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections B through E. See right column for detailed instructions.
6. Be sure to include the date and your signature at the bottom of the form.
7. Once the form is complete (including Section A), the subscriber should retain the last copy for their records to use as a temporary ID card.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing Sections A through E:

Section A: The employer must complete all fields to ensure we have correct account and enrollment reason information. **The employer is responsible for confirming all information submitted by the subscriber, especially effective dates as they affect your Health Plan dues.**

Section B: The subscriber must indicate the requested change they are making to their account. They must then complete the other sections indicated. Please print legibly in black or dark blue ink.

Section C: The subscriber must always complete this section, even when making minor changes to the account. This ensures our information is current. Please mark the box if your address is new. Always include your Medical Record Number.

Section D: The subscriber should complete this section to notify Kaiser Permanente of a name change. Include both the prior name and the new name.

Section E: The subscriber should complete this section when adding, updating, or deleting dependent information. Include any prior last names for both spouse and dependents. Include their Kaiser Permanente Medical Record Number, if they have one. Include the reason and event date for the dependent addition or deletion from the table below.

Addition/Deletion Reasons and Event Dates

Add Dependent Reason	Event Date
Acquired Student Status	Date Student Status Was Obtained
Family Adoption	Date of Adoption
Loss of Coverage	Date Coverage Was Lost
New Spouse	Date of Marriage
Moved into Service Area	Move Date
Newborn Addition	Date of Birth
Open Enrollment	Open Enrollment Effective Date

Delete Dependent Reason	Event Date
Loss of Student Status	Date of Status Change
Divorce	Date of Divorce
Member Deceased	Date of Death
Delete Dependent(s)	Dependent Termination Date
Open Enrollment	Open Enrollment Effective Date