2023 Oregon Small Group Employee Enrollment/Change Form

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

Please print in black or blue ink only.

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name[1] Divine Hardwood & Stone, Inc

Group #[1] 20641 Effective date of coverage[1] ____ / ____ / ____

Medical subgroup # ____ Billgroup ____

Family dental subgroup # ____ Billgroup ____

Pediatric only dental subgroup # (18 years and younger) ____ Billgroup ____

Enrollment/change reason – complete if existing group[1] *(Please check one.)*

☐ New hire ☐ Open enrollment ☐ Part-time to full-time

☐ Newborn ☐ COBRA ☐ Change ____

☐ Loss of coverage ☐ State continuation ☐ Other ____

A Employee information *(Employee completes sections A, B, and C.)*

Select benefit type:[1]

Medical ☐ ____ *(plan choice)*

Dental (select one): ☐ Family (adult and pediatric) ____ *(plan choice)*

☐ Pediatric only (18 years and younger) ____ *(plan choice)*

☐ Waiving pediatric dental[2]

Legal name *(last, first, MI)*[1] ____

Former/maiden name *(if any)* ____

Date of birth[1] ____ / ____ / ____ Social Security # ____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) ____

Home address[1] ____ Apt. ____

City ____ State ____ ZIP ____ Email ____

Mobile phone ____ Home phone ____

Medical record # *(if any)* ____ Preferred language ____

B Dependent information *(For additional dependents, please use our Addendum to Oregon Small Group Employee Enrollment/Change Form.)*

Select one: ☐ Spouse/registered domestic partner[3] ☐ Non-registered domestic partner

Legal name *(last, first, MI)*[1] ____ Date of birth[1] ____ / ____ / ____

Social Security # ____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Pronoun(s) ____ Mobile phone ____ Disabled ☐ Yes ☐ No

☐ Medical

Dental (select one): ☐ Family (adult and pediatric) ☐ Pediatric only (18 years and younger) ☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. ____

Policy # ____ Medical record # *(if any)* ____

[1]Required *(continues on back)*

[2]By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.

[3]A person who is legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.

B Dependent information *(continued)*

Dependent (child) legal name *(last, first, MI)*[1,3] _____

Date of birth[1] ____ / ____ / ____ Social Security # _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____

Mobile phone _____ Disabled ☐ Yes ☐ No

☐ Medical

Dental (select one): ☐ Family (adult and pediatric) ☐ Pediatric only (18 years and younger) ☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy # _____ Medical record # *(if any)* _____

Dependent (child) legal name *(last, first, MI)*[1,3] _____

Date of birth[1] ____ / ____ / ____ Social Security # _____

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____

Mobile phone _____ Disabled ☐ Yes ☐ No

☐ Medical

Dental (select one): ☐ Family (adult and pediatric) ☐ Pediatric only (18 years and younger) ☐ Waiving pediatric dental[2]

Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy # _____ Medical record # *(if any)* _____

☐ Check here to add additional dependents and attach the Addendum to Oregon Small Group Employee Enrollment/Change Form.

C Important – *Your application cannot be processed without your signature. Please read the entire form before signing.*

If you make an intentional misrepresentation of material fact through misstatement or omission, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on this form.

Employee signature[1] _____ Date ____ / ____ / ____

Print name: _____

[1]Required
[2]By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.
[3]Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental disability, mental illness, or a physical disability.
Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

KAISER PERMANENTE®

Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.

Member rights and responsibilities

For more information about Kaiser Permanente member rights and responsibilities, go to **kp.org/disclosures** and select "Oregon/SW Washington" from the pull-down menu.

Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly delay the enrollment process.

By mail:
Kaiser Permanente
P.O. Box 23127
San Diego, CA 92193

By fax:*
1-855-355-5334

By email:
18553555334@fax.kp.org

Plan details, including all benefits, exclusions, and limitations, are provided in the *Evidence of Coverage (EOC).* To get an *EOC* for a particular plan, contact Member Services. In the event of any conflict between this brochure and the *EOC,* the *EOC* prevails.

*Please limit fax submissions to one enrollment form per transmission.

KAISER PERMANENTE®

How to fill out this form

1. Please print legibly in black or blue ink.

2. To be enrolled, you must live or work within the Northwest service area at least 50% of the time, unless you are an Added Choice® out-of-area member.

3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting this form, especially effective dates, as these affect your premium.

4. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. Read section C and the entire form. Then sign and date the form.

5. Once the form is complete, retain a copy for your records. (You will soon have access to a digital Kaiser Permanente ID card and will receive a physical ID card in the mail.)

All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.

Member Services

Monday through Friday, 8 a.m. to 6 p.m.

1-800-813-2000

or

1-866-616-0047 for Kaiser Permanente Plus™ and Added Choice® members

For TTY, call **711.** For language interpretation services, call **1-800-324-8010.**

Get connected

Follow the simple steps on the left side of this page to enroll in your plan.

I'm a new member!

Create your online account

Enjoy around-the-clock, secure access to care with online features that can save you time and money. Once you are registered, you can email your doctor's office, view most lab results, refill most prescriptions, schedule routine virtual or in-person appointments, and much more.* Go to **kp.org/newmember** to get started.

Your ID card

After your enrollment has been processed, you can create your online account through the Kaiser Permanente app or **kp.org/newmember**. And you can now access your digital ID card on the Kaiser Permanente app before receiving a physical ID card in the mail. This card will contain your name and unique 8-digit medical record number. You'll want to have your digital ID card or physical card handy when you call for 24/7 advice or come to us for care.

New Member Welcome Desk

We are here to help you and your family understand your plan and connect to care. If you have questions or need help, call or schedule an appointment with our New Member Welcome Desk at **1-888-491-1124,** Monday through Friday, 8 a.m. to 5 p.m.

Choose your doctor – and change any time

Go to **kp.org/newmember** to browse our doctor profiles and find a doctor who matches your needs.

Transfer your prescriptions

If you have prescriptions to transfer, you'll want to fill out the Transfer Your Prescriptions Form at **kp.org/newmember** right away, or you can contact the New Member Pharmacy at **1-888-572-7231** for help. You can usually receive a one-time refill of a prescription written by a nonparticipating or out-of-network provider if the medication is on our formulary and your prescription allows for refills.

*These features apply to care you get at Kaiser Permanente facilities.

KAISER PERMANENTE®

869799856_FF_04-22