# 2024 Oregon Small Group Employee Enrollment/Change Form



Please print in black or blue ink only.

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

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

Company name <sup>1</sup>						
Group #1		_ Effecti	ve date of covera	nge <sup>1</sup>	_/	/
Medical subgroup #				Billgroup		
Family dental subgroup #				Billgroup		
Pediatric only dental subgroup # (18 years and younger)				Billgroup		
Enrollment/change	reason – complete if ex	isting gro	up¹ (Please che	ck one.)		
☐ New hire	☐ Open enrollment	Ċ	☐ Part-time	to full-time		
$\square$ Newborn	□ COBRA		$\square$ Change $\_$			
☐ Loss of coverage	☐ State continuatio	n	$\square$ Other $\_\_$			
A Employee info	rmation <i>(Employee co</i>	mpletes s	sections A, B, a	nd C.)		
Select benefit type:	1					
Medical 🗆						(plan choice)
Dental (select one):	$\square$ Family (adult and ped	liatric)				(plan choice)
	☐ Pediatric only (18 yea	ırs and yoı	unger)			(plan choice)
	☐ Waiving pediatric de	•				,
Legal name (last, firs	t, MI) <sup>1</sup>					
Former/maiden nam	ne (if any)					
	//					
	X □ Decline to provide (					
Home address <sup>1</sup>					A	npt
City	State	ZIP	Email			
Mobile phone			. Home phone			
Medical record # (if a	any)		Preferred langua	age		
	ormation (For addition ee Enrollment/Change		ndents, please u	ise our Adden	idum to (	Oregon Small
Select one: Spou	se/registered domestic p	artner <sup>3</sup> [	☐ Non-registered	domestic part	ıner	
Legal name (last, firs	st, MI) <sup>1</sup>			Date of Ł	oirth <sup>1</sup>	//
Social Security #			Sex¹ □M □	]F □X □De	cline to p	rovide (at this time)
Pronoun(s)	N	Mobile pho	one		Disa	abled □Yes □No
☐ Medical						
Dental (select one):	∃Family (adult and pediatri	ic) 🗌 Pedi	iatric only (18 year	s and younger)	□Waivir	g pediatric dental <sup>2</sup>
Other health insurar	nce □Yes □No		Insurance co	O		
Policy #			Medical rec	ord # (if any)		
1Required 2By checking this box	y you are attesting that the	mambar h	as podiatric donts	al coverage else	whore	(continues on back)

<sup>2</sup>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.

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<sup>&</sup>lt;sup>3</sup>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) <sup>1,3</sup>						
Date of birth <sup>1</sup> / Social Security						
Sex <sup>1</sup> $\square$ M $\square$ F $\square$ X $\square$ Decline to provide (at this time)						
Mobile phone	Disabled □Yes □No					
☐ Medical						
Dental (select one): $\square$ Family (adult and pediatric) $\square$ Pediatri	c only (18 years and younger) Waiving pediatric dental <sup>2</sup>					
Other health insurance $\square$ Yes $\square$ No	Insurance co					
Policy #	Medical record # (if any)					
Dependent (child) legal name (last, first, MI) <sup>1,3</sup>						
Date of birth <sup>1</sup> / Social Security						
$Sex^1 \square M \square F \square X \square Decline to provide (at this time)$						
Mobile phone	Disabled □Yes □No					
☐ Medical						
Dental (select one): Family (adult and pediatric) Pediatric only (18 years and younger) Waiving pediatric dental <sup>2</sup>						
Other health insurance $\square$ Yes $\square$ No	Insurance co					
Policy #	Medical record # (if any)					
☐ Check here to add additional dependents and attach the Enrollment/Change Form.						
C Important – Your application cannot be processed before signing.	without your signature. Please read the entire form					
If you make an intentional misrepresentation of material fact Health Plan of the Northwest (KFHPNW) may, within the first the contract, and/or take any other legal action available to in writing if anything happens before coverage takes effect may be a crime to knowingly provide false, incomplete, or repurpose of defrauding the company. Penalties may include	t two years of coverage, deny coverage, modify or cancel it by law. Applicant must promptly inform KFHPNW that makes the application incomplete or incorrect. It misleading information to an insurance company for the					
I acknowledge by my signature that the information I have seried and agree to the requirements, terms, conditions, limit	• •					
Employee signature <sup>1</sup>	////					
Print name:						
<ul> <li><sup>1</sup>Required</li> <li><sup>2</sup>By checking this box you are attesting that the member has per essential health benefits provision of the Affordable Care Act.</li> <li><sup>3</sup>Eligible through the last day of the month of their 26th birthday</li> </ul>						

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.



## 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 <u>kp.org/disclosures</u> 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:\* By email: 1-855-355-5334 csc-den-ro

csc-den-roc-group@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.



<sup>\*</sup>Please limit fax submissions to one enrollment form per transmission.

### 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.)

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 <a href="kp.org/newmember">kp.org/newmember</a> 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. You can now access your digital ID card on the Kaiser Permanente app, which contains 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.

