# 2027 Oregon Small Group Employee Enrollment/Change Form

KAISER PERMANENTE®

*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[1] _____

Group #[1] _____ Effective date of coverage[1] _____ / _____ / _____

Medical subgroup # _____ Billgroup _____

Family dental subgroup # _____ 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[2] ☐ _____ *(plan choice)*

Dental: ☐ Family dental (adult and pediatric) _____ *(plan choice)*

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[3] _____ 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[4] ☐ 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[3] _____ Disabled ☐ Yes ☐ No

☐ Medical[2]

☐ Family dental (adult and pediatric)

Other health insurance ☐ Yes ☐ No Insurance co. _____

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

*(continues on back)*

[1] Required.

[2] Oregon Standard medical plans do not include pediatric dental coverage (pediatric dental coverage is included in all other medical plans). If you're enrolling on a Standard plan and would like to obtain certified pediatric dental coverage for members 18 and younger, you may select a family dental plan, if offered by your employer.

[3] Required for those who are 18 and older.

[4] 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)*[1,2] _____

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

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

Mobile phone[3] _____ Disabled ☐ Yes ☐ No

☐ Medical[4]

☐ Family dental (adult and pediatric)

Other health insurance ☐ Yes ☐ No Insurance co. _____

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

Dependent (child) legal name *(last, first, MI)*[1,2] _____

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

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

Mobile phone[3] _____ Disabled ☐ Yes ☐ No

☐ Medical[4]

☐ Family dental (adult and pediatric)

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] 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.
[3] Required for those who are 18 and older.
[4] Oregon Standard medical plans do not include pediatric dental coverage (pediatric dental coverage is included in all other medical plans). If you're enrolling on a Standard plan and would like to obtain certified pediatric dental coverage for members 18 and younger, you may select a family dental plan, if offered by your employer.

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## 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.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

## 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:***
1-866-311-5974

**By email:**
commercial-membership-moc@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.

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## 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 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 **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**. 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 can do so either online at **kp.org/newmember** or by calling **1-866-616-0047** (TTY **711**). 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.

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# NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

## Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

This notice is available at **https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice**.


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**For Washington Members:**
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

## Help in Your Language

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

**አማርኛ (Amharic) ትኩረት፡** አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

**العربية(Arabic) تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** ( TTY: **711**).

**中文 (Chinese) 注意事項：**如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（TTY：**711**）。

**فارسی(Farsi) توجه:** اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** تماس بگیرید (TTY (تلفن متنی): **711**).

**Français (French) ATTENTION :** si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

**日本語 (Japanese) 注意：**日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY: **711**）。

**ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖** បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

**ລາວ (Laotian) ເອົາໃຈໃສ່:** ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

**Afaan Oromoo (Oromo) XIYYEEFFANNOO:** Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira.
**1-800-813-2000** irratti bilbilaa (TTY:- **711**)

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

**Română (Romanian) ATENȚIE:** Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

**Русский (Russian) ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

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**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

**ไทย (Thai) โปรดทราบ:** หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

**Українська (Ukrainian) УВАГА!** Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).



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