

# Denver/Boulder/Longmont Group Enrollment/Change Form

Please review entire form; print or type in black ink only.  
Retain pink copy for your records and use as a temporary ID after the effective date.

EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

**TO BE COMPLETED BY EMPLOYER**

COMPANY NAME

GROUP NO.

SUBGROUP NO.

BILLGROUP UNIT

DATE OF HIRE (MM/DD/YYYY)

EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

**NEW ENROLLMENT** Check one:

 New group

 Open enrollment (complete sections A, B, C, D)

 New hire (complete sections A, B, C, D)

 COBRA (complete sections A, B, C, D)

 Loss of other coverage (complete sections A, B, C, D)

 Date of event 
 Other (please specify) \_\_\_\_\_

**PLAN** Check one:

HMO

PPO

Added Choice (Point-of-Service)

Out-of-Area

Deductible/Coinsurance

Deductible/Coinsurance w/HSA option

**IF MAKING A CHANGE, COMPLETE THE FOLLOWING:**
**DELETE DEPENDENTS** (Complete sections A, B, C, D)

DATE (MM/DD/YYYY)

 Over age limit

 Divorce

 Deceased

 Other (please specify) \_\_\_\_\_

**ADD DEPENDENTS** (Complete sections A, B, C, D)

DATE (MM/DD/YYYY)

 Birth

 Adoption\*

 Marriage

 Domestic partner (if applicable)

 Loss of other coverage

 Other (please specify) \_\_\_\_\_

**OTHER CHANGES**
 Name change (Complete sections A, B, C )

 Address (complete sections A, C)

Previous name \_\_\_\_\_

 Telephone (complete sections A, C)

Current name \_\_\_\_\_

 Are you or any of your dependents eligible for Medicare? If yes, please contact **1-800-632-9700** for details.


**A. EMPLOYEE INFORMATION**

LAST NAME FIRST NAME MI SUFFIX  
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE  
 PCP ID Current patient:  
 Primary care physician (PCP) \_\_\_\_\_  Yes  No  
 ADDRESS  
 APARTMENT NUMBER CITY  
 STATE ZIP CODE HOME PHONE WORK PHONE  
 PREFERRED SPOKEN OR WRITTEN LANGUAGE (OPTIONAL) ETHNICITY (OPTIONAL)

**B. FAMILY INFORMATION** For additional dependents, please attach a separate sheet and put employee's name at the top.

Check here if you've attached an additional sheet.

ADD  DELETE  SPOUSE  DEPENDENT  CHILD  OTHER  \_\_\_\_\_  
 LAST NAME FIRST NAME MI SUFFIX  
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE  
 PCP ID Current patient:  
 Primary care physician (PCP) \_\_\_\_\_  Yes  No

ADD  DELETE  DEPENDENT  CHILD  OTHER  \_\_\_\_\_  
 LAST NAME FIRST NAME MI SUFFIX  
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE  
 PCP ID Current patient:  
 Primary care physician (PCP) \_\_\_\_\_  Yes  No

ADD  DELETE  DEPENDENT  CHILD  OTHER  \_\_\_\_\_  
 LAST NAME FIRST NAME MI SUFFIX  
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE  
 PCP ID Current patient:  
 Primary care physician (PCP) \_\_\_\_\_  Yes  No



EMPLOYEE LAST NAME <input style="width:95%; height: 20px;" type="text"/>	SOCIAL SECURITY NUMBER <input style="width:95%; height: 20px;" type="text"/>
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Are any of your listed dependents over the maximum age? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please complete the following:			
Name(s) (Last, First, MI)	Disabled*	Full-time student	Name of college, university, or trade school
<hr/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<hr/>
<hr/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<hr/>

**C. Conditions for Enrollment: I have read and agree to the terms and conditions on the reverse side of this enrollment form.** Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in CRS 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

I hereby apply for Kaiser Permanente membership for myself and eligible family dependents listed on this form. I understand that if I/we, are accepted for membership, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

Employee/Applicant signature	Date	Employer signature	Date
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**D. OTHER COVERAGE INFORMATION**  
 Including yourself, do any of the persons listed above have other coverage? YES  NO

Name	Insurance carrier name	Policy number	Telephone number
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Is your spouse employed? YES <input type="checkbox"/> NO <input type="checkbox"/>	Are your children employed? YES <input type="checkbox"/> NO <input type="checkbox"/>
Does your spouse have additional insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>	Do your children have additional insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>

**EMERGENCY CONTACT**

Name and relationship to you	Daytime phone number	Evening phone number
<hr/>	<hr/>	<hr/>

\*Additional documentation may be required.



**THIS KAISER PERMANENTE FORM MAY BE USED FOR ANY OF THE FOLLOWING REASONS:**

- Enrollment/open enrollment
- Change of information
- Cancellation of coverage

Please call Member Services at **303-338-3800** or **1-800-632-9700** (TTY **303-338-3820**) if

- you would like to convert from group to individual coverage, or
- you or any of your dependents are eligible for Medicare, or
- you need help completing this application.

**HOW TO COMPLETE THIS FORM**

Please fill in all sections of the form that apply to you. If information we need is missing, your enrollment may be delayed. If you're unclear about any of the information being requested, call Member Services at **303-338-3800** or **1-800-632-9700** (TTY **303-338-3820**). Please print with a black ballpoint pen and press hard. Give the white and yellow copies of your completed form to your employer. Your employer will mail the white copy of the enrollment form to Kaiser Permanente, Membership Administration Department, P.O. Box 921010, Fort Worth, TX 76121-1010. Keep the pink copy for temporary identification in case you need care before you receive your Kaiser Permanente ID card.

**TO ENROLL**

- Employer: Complete section of the form titled "To be completed by employer." Employee: Complete all sections of the form except the section titled "To be completed by employer."
- If you're enrolling current or past Kaiser Permanente members, please fill in Section B. If they were enrolled under a different name, please provide that name.

**TO CHANGE MEMBERSHIP INFORMATION\***

- If you're adding a dependent because of adoption, fill in the date the child was placed in your home. Attach a copy of the confirmation letter from the adoption agency.
- If you're adding a dependent because of marriage, fill in the date of your marriage.
- If you're adding a dependent because you have permanent legal guardianship, attach a copy of your legal guardianship papers.
- If you're deleting a dependent because of death, fill in the date of death.
- If you're changing your name, fill in the previous and current name(s).
- Complete if you or any dependents are eligible for Medicare.

**SECTION A—Employee information (Complete all parts of this section if you are enrolling.)**

- We need your primary (no P.O. boxes) address to send you important items such as your Kaiser Permanente ID card.
- Stating your ethnicity and language is optional. This information can help Kaiser Permanente meet the health care needs of our members. It will be kept confidential.

**SECTION B—Family information (Complete if you are enrolling or deleting eligible dependents.)**

- Fill in the requested information for dependents you want to enroll or delete from coverage. List a primary care physician (PCP) for each member. If you're only enrolling yourself, don't list any dependents in this section. If you're enrolling more than two dependent children, please check the box indicated on the enrollment form and attach an additional sheet. For those children, provide the information requested on the form. (Note: Dependents must be added within 31 days of becoming eligible.)
- Your plan covers children only up to a certain age, unless a child is disabled or a full-time student at a college, university, or trade school.
- To cover a child who is older than your plan's age limit and is a full-time student, fill in the name and check "yes" for full-time student. Also fill in the name of the school.
- If you believe any of your children may qualify as a disabled dependent, fill in the name and check "yes" for disabled. In this case, you'll receive additional instructions by mail.

**SECTION C—Read the "Conditions for enrollment" and sign and date this form.**

(continued on inside panel)

**SECTION D—(Review and complete if applicable.)****Other coverage information**

- Fill in this section if you or any of your dependents currently have, or previously have had, insurance coverage through any other health plan, including Medicare.

**Emergency contact**

- Provide name, relationship, and phone numbers for your emergency contact.

**ONCE YOU HAVE COMPLETED THIS FORM**

The *white* copy is for Kaiser Permanente—please return it to your employer or mail it to:

Kaiser Permanente  
Membership Administration Department  
P.O. Box 921010  
Fort Worth, Texas 76121-1010

The *yellow* copy is for your employer.

The *pink* copy is for you.

- If you are a new member, use your *pink* copy as temporary identification until your Kaiser Permanente identification card arrives in the mail.
- If you are a current member making changes to your account, keep the pink copy for your records.  
Call Member Services at **303-338-3800** or **1-800-632-9700** (TTY **303-338-3820**) if you need assistance in filling out this form.

**COORDINATION OF BENEFITS**

If you and your family are covered by more than one health plan, you may be able to save money while improving your coverage.

Often, when a husband and wife are both employed, they may each have health coverage provided by their employers.

If you are covered by two plans that include a Coordination of Benefits (COB) provision, you may be able to eliminate most of your out-of-pocket expenses for services now only partially covered by those plans.

When you receive services authorized by Kaiser Permanente, we will bill your primary carrier for you and set up a benefit reserve account.

Kaiser Permanente will keep track of any savings we receive from your primary carrier and credit it into a benefit reserve account for you.

The money in the benefit reserve account is used to reimburse you for out-of-pocket expenses for medical services that are only partially covered by either of your health plans. Incurred expenses applied to the benefit reserve account must occur in the same calendar year.

To take advantage of this benefit, be sure to complete the "Other coverage information" in Section D on the back of the enrollment/change form.

If you have any questions or need more information about Coordination of Benefits, call Patient Business Services at **303-743-5900**.

**COORDINATION OF BENEFITS AUTHORIZATION**

I hereby authorize Kaiser Permanente to bill my spouse's or any other dependent's primary group insurance carrier for all services provided or arranged by Participating Physicians and to coordinate benefits and/or reimbursements with other health or insurance companies. I request that payment be made to Kaiser Permanente on any bills for services furnished for myself or any dependents on my plan. I also authorize Kaiser Permanente to release any information regarding the medical treatment needed for this claim. I further authorize this copy to be used in place of the original.

**ADVANCE DIRECTIVES**

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes: CRS 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive and will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facilities if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (CRS 15-14-507)

Two brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call Member Services at **303-338-3800** or **1-800-632-9700** (TTY **303-338-3820**).

**TERMS AND CONDITIONS**

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel my membership, and/or refuse to pay claims. I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if this application is accepted by Kaiser Permanente, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

I authorize payroll deduction for whatever amounts are necessary to pay my health plan coverage.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**