2019 Oregon Large 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.

This section must be filled out in full by the employer. Please print or type legibly.

Company name[1] ______________________ Effective date of coverage[1] ___ / ___ / ___

Medical group no.[1] ____________ Medical subgroup no.[1] ____________ Billgroup[1] ____________

Dental group no. ____________ Dental subgroup no. ____________ Billgroup ____________

Enrollment/change reason — complete if existing group[1] *(Please check one.)* Event date ___ / ___ / ___

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part-time to full-time ☐ Change ____________

☐ Open enrollment ☐ COBRA ☐ State continuation ☐ Other/qualifying event ____________

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

Select benefit type: ☐ Medical ____________ (plan choice) ☐ Dental ____________ (plan choice)

Name *(last, first, MI)*[1] ______________________ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Former/maiden name *(if any)* ____________ Date of birth[1] ___ / ___ / ___ Social Security no.[1] ____________

Home address[1] ______________________ Apt. ______

City ____________ State ____ ZIP ______ Email ____________

Home phone[1] ____________ Work phone ____________

Health record no. *(if any)* ____________ Preferred language ____________ Ethnicity ____________

B Dependent information (For additional dependents, please use our Addendum to Oregon Group Employee Enrollment/Change Form. If this is for additions of dependents, please include all dependents whom you want to remain on the plan after the change effective date.)

☐ Spouse ☐ Domestic partner[2] Name *(last, first, MI)* ______________________ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] ____________

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________

Policy no. ____________ Health record no. *(if any)* ____________

Dependent (child) name *(last, first, MI)* ______________________ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] ____________

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________

Policy no. ____________ Health record no. *(if any)* ____________

Dependent (child) name *(last, first, MI)* ______________________ Disabled ☐ Yes ☐ No

Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Date of birth[1] ___ / ___ / ___ Social Security no.[1] ____________

☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________

Policy no. ____________ Health record no. *(if any)* ____________

☐ Check here to add additional dependents and attach the Addendum to Oregon Group Employee Enrollment/Change Form. Include employee name and Social Security number on 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 ___ / ___ / ___

[1] *Required*

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