KAISER PERMANENTE®

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Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Addendum to Employee Enrollment/Change

This form must accompany the Employee Enrollment/Change form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Employee Enrollment/Change form.

This section to be completed by the employer.

Company name* _____   Effective date of coverage* ____ / ____ / ____

Group no.* _____   Medical subgroup no. _____   Dental subgroup no. _____

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

Name *(last, first, MI)** _____   Former/maiden name *(if any)* _____

Gender* ☐ M ☐ F   Date of birth* ____ / ____ / ____   Social Security no. _____

B Dependent information

Child name *(last, first, MI)* _____   ☐ Full-time student   Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F   Date of birth* ____ / ____ / ____   Social Security no. _____   ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No   Insurance co. _____   Policy no. _____

Health record no. (if any) _____   Medicare eligible ☐ Yes ☐ No   Medicare ID no. _____

Child name *(last, first, MI)* _____   ☐ Full-time student   Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F   Date of birth* ____ / ____ / ____   Social Security no. _____   ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No   Insurance co. _____   Policy no. _____

Health record no. (if any) _____   Medicare eligible ☐ Yes ☐ No   Medicare ID no. _____

Child name *(last, first, MI)* _____   ☐ Full-time student   Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F   Date of birth* ____ / ____ / ____   Social Security no. _____   ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No   Insurance co. _____   Policy no. _____

Health record no. (if any) _____   Medicare eligible ☐ Yes ☐ No   Medicare ID no. _____

Child name *(last, first, MI)* _____   ☐ Full-time student   Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F   Date of birth* ____ / ____ / ____   Social Security no. _____   ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No   Insurance co. _____   Policy no. _____

Health record no. (if any) _____   Medicare eligible ☐ Yes ☐ No   Medicare ID no. _____

☐ Check here if another Addendum to Employee Enrollment/Change form is attached.

C Important

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee signature* _____   Date ____ / ____ / ____

*Required