SF 4400-KAI (6-2001)

KAISER PERMANENTE

UCI

Enrollment Application or Change Form

Please print or type in black or dark blue ink only. Please see instructions on next page *before* completing this form.
Retain a copy for your records and use as a temporary ID.

A. TO BE COMPLETED BY EMPLOYER

Purchase Number - **Enrollment Unit Number**		**Company Name or Trust Fund Name**
Employer ID - **Effective Date**		**Company Address or Trust Fund Address**

B. ENROLLMENT (check only one) -- OR -- CHANGE (check all that apply)

☐ New Hire Enrollment – Date of Hire: _____

☐ Part Time to Full Time – Date: _____

☐ Open Enrollment

☐ Other: _____ Event Date: _____
See Section 1A on reverse side for options.

☐ Add Dependent: _____ Event Date: _____
Enter reason and date from Section 1B on instruction page. Complete Sections C and F below.

☐ Delete Dependent: _____ Event Date: _____
Enter reason and date from Section 1C on instruction page. Complete Sections C and F below.

☐ Name Change – Complete Sections C and D

☐ Address Change – Complete Sections C and E

C. EMPLOYEE/SUBSCRIBER INFORMATION

Are you now or have you ever been a Kaiser Permanente member? ☐ Yes ☐ No If so, what is/was your Medical Record Number? _____

Have you ever received care from Kaiser Premanente within the state of California? ☐ Yes ☐ No

Under what name: _____ Maiden/Other

- - Social Security Number | Last Name | First Name | MI

Date of Birth | Gender: ☐ M ☐ F | Marital Status: ☐ Married ☐ Single

Preferred Language Spoken | Preferred Language Written | Employee ID | Employment Status: ☐ Working ☐ Retired

Street Address | City | State | ZIP Code

( ) Day Phone | ( ) Evening Phone | E-mail Address (Optional)

D. NAME CHANGE

FROM: Last Name | First Name | MI — To: Last Name | First Name | MI

E. ADDRESS CHANGE

OLD Street Address | City | State | ZIP Code

NEW Street Address | City | State | ZIP Code

F. LIST FAMILY MEMBERS TO BE ADDED OR DELETED (attach additional sheet, if needed)

Last Name	First Name	MI	Role	Social Security Number	Date of Birth MM/DD/YY	Gender	Add/ Delete	Medical Record Number if Known
Spouse *Maiden/Other:*			☐Spouse ☐Domestic Partner	- -		☐M ☐F	☐Add ☐Delete	
Dependent *Relationship:*			☐Spouse ☐Domestic Partner	- -		☐M ☐F	☐Add ☐Delete	
Dependent *Relationship:*			☐Spouse ☐Domestic Partner	- -		☐M ☐F	☐Add ☐Delete	
Dependent *Relationship:*			☐Spouse ☐Domestic Partner	- -		☐M ☐F	☐Add ☐Delete	

Dependent's Address (if different from subscriber): ☐ Check here if all dependents are at the address below.

Name(s)	Address	City	State	Zip Code

I understand that, except for Small Claims Court cases and claims subject to the Medical Appeals Procedure, any claim that I, my heirs, or other claimants associated with me assert for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the *Evidence of Coverage.*

Employee/Subscriber Signature **Date**

FIRST COPY – To Kaiser Permanente (CSC) **SECOND COPY** – To be retained by purchaser **THIRD COPY** – **To be retained by subscriber and used as temporary ID**