KAISER PERMANENTE®

COBRA Enrollment Form

This enrollment form must not be submitted to Kaiser Permanente. Ask your former employer where you should send this form. Complete all fields or you may have a delay in your enrollment. Please print or type in black or dark blue ink only.

TO BE COMPLETED BY EMPLOYER

Purchaser/Enrollment Unit Number	Employer	Employer Signature/Date

Enrollment Information

Please check the reason for enrollment and complete the maximum months of coverage. NOTE: If requesting a transfer of an existing COBRA account from another carrier to Kaiser Permanente, you must indicate the qualifying event for the initial COBRA enrollment.

Reason for COBRA Enrollment

☐ Date of termination of employment: MO _____ DAY _____ YEAR _____
☐ Date of reduction of work hours: MO _____ DAY _____ YEAR _____
☐ Loss of spousal or dependent status: Effective Date of Loss: MO _____ DAY _____ YEAR _____
Reason for loss: ○ Marriage ○ Divorce or legal separation ○ Death of subscriber ○ Reached maximum age ____
○ Subscriber's Medicare entitlement ○ Other _____
☐ Transfer of existing COBRA account from another carrier to Kaiser Permanente
Carrier's Name & Telephone Number _____
Policy Number _____ Policy Term Date _____
Original initial COBRA enrollment reason _____
Original initial COBRA coverage start date _____

Maximum months of coverage _____

Additional Enrollment Information

☐ Qualified beneficiary on the account is disabled pursuant to US Social Security Act
☐ Applying for Health Care Tax Credit (TAA/HCTC) through the Federal Government.
(Please attach a copy of your potential eligibility letter.)

TO BE COMPLETED BY EMPLOYEE

Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage may be enrolled as part of your COBRA account. (Attach additional sheet, if needed.)

Subscriber Information

Name: *(Last/First/MI)*	Social Security number	Date of birth	Gender
			M☐ F☐

Address: *(Street/City/State/ZIP)*

Day phone number	Alternate phone number	Email address (for enrollment purpose only)

During this employment was Kaiser Permanente your group coverage? ❑ Yes ❑ No

Family Information

	Name: *(Last/First/MI)*	Role	Social Security number	Date of birth	Gender
Spouse or domestic partner (if eligible)		○ Spouse ○ Domestic partner			M ☐ F ☐
Dependent		○ Child ○ Student			M ☐ F ☐
Dependent		○ Child ○ Student			M ☐ F ☐

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the Group health plan documents, including the Evidence of Coverage. I have reviewed the statements on this form and they are true and correct. The Health Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Form.

Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company Arbitration Agreement*: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance.*

** Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.*

_____ _____

Signature Required for all Kaiser Permanente Plans
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

Date

Guidelines for completing this form

1. Complete all applicable fields on the form. Use only dark blue or black ink. Please print clearly.
2. Complete and sign this enrollment form. The subscriber (employee) must sign the form; or, in the case of spouse domestic partner (if eligible) or dependent making their own individual election, such individual must sign the form. With respect to an individual under the age of 18, the parent or legal guardian must sign the form. Include information on all dependents to be covered.
3. The subscriber (employee) on the group coverage account is not required to be enrolled in the COBRA account. If the employee does not enroll in COBRA, please specify who the new subscriber on the account should be in the "Subscriber Enrollment Information" section of the form.
4. Your spouse (or domestic partner, if eligible) or dependent children are eligible to enroll if they were covered under your Kaiser Permanente group plan. Dependents may be added only during open enrollment, or under the special enrollment provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996).
5. Do not submit payment with this form. Your former employer will instruct you on how to make your payments.
6. For enrollment in a COBRA account, check with your former employer as to where to submit the form. Do not mail or fax it to us.
7. Be sure to include the Social Security Numbers of any members who are, or have ever been, Kaiser Permanente members. We will use this number to ensure that they retain the same Medical Record Number that they may have been assigned in the past.
8. Only new members will receive an ID card. Existing members will not receive new cards. Please continue to use your existing card.
9. If you are transferring your existing COBRA account from another carrier to Kaiser Permanente during Open Enrollment, be sure to include the original reason why you were initially eligible for your COBRA coverage, and identify your other carrier's name and your original start date.

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Federal COBRA Enrollment Form

Please read instructions. Both the employer and the employee must complete fields on this form to request enrollment in a Kaiser Permanente group COBRA account.

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