KAISER PERMANENTE®

Georgia Small Business

EMPLOYEE ENROLLMENT FORM

(1-50 EMPLOYEES)

Check Plan Type:	Check Enrollment Type:	Fill Out Sections:
☐ KP/HDHP	☐ New Hire	A, B, C, D
☐ Dual Choice PPO	☐ Annual Enrollment	A, B, C, D
	☐ COBRA Enrollment	A, B, C, D

To be Completed by Employer

Effective Date ____/____/____

Group Number _____

Sub Group _____

Bill Group _____

A EMPLOYEE INFORMATION

Note: Please print and use blue or black ink Language Preference _____

Last Name	First Name	MI	Gender ☐ M ☐ F

Date of Birth / /	Social Security Number – –	E-mail Address	Ethnicity (optional)

Address	City	State	Zip Code

Home Phone	Job Title	Marital Status ☐ Married ☐ Single ☐ Domestic Partner

☐ Check if you are an existing or previous member.	Please provide your Health Record Number. Health Record Number or HRN#

Company Name	Hours Worked	Employment Status ☐ Active ☐ COBRA

Are you an independent contractor? ☐ Yes ☐ No

B COVERAGE STATUS

☐ Self Only ☐ Self + Spouse/DP ☐ Self + Child(ren) ☐ Self + Spouse + Child(ren)

SPOUSE/DOMESTIC PARTNER

Last Name	First Name	MI	Check if existing member. ☐

Date of Birth / /	Gender ☐ M ☐ F	Social Security Number – –	Health Record Number or HRN#

DEPENDENT 1

Last Name	First Name	MI	Check if existing member. ☐

Date of Birth / /	Gender ☐ M ☐ F	Social Security Number – –	Health Record Number or HRN#

DEPENDENT 2

Last Name	First Name	MI	Check if existing member. ☐

Date of Birth / /	Gender ☐ M ☐ F	Social Security Number – –	Health Record Number or HRN#

Continued

B COVERAGE STATUS CONTINUED

DEPENDENT 3

Last Name	First Name	MI	Check if existing member. ☐

Date of Birth / /	Gender ☐M ☐F	Social Security Number – –	Health Record Number or HRN#

C PLEASE SIGN APPLICATION

Please complete this application and submit it to your company's Benefits Administrator. I understand and agree that if the application is accepted by Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and /or Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, and my dependents (if any) will be eligible will be in accordance with the Group Agreement and/or Group Policy, as applicable, to the type of plan for which we are enrolled. I further understand and agree that I, and my dependents (if any) will be bound by the terms and conditions of such agreements. I authorize the deduction from my wages, amounts necessary to pay the employee portion of the premiums for my, and my covered dependents' (if any) Health Plan and/or KPIC, as applicable, coverage. I understand that to be eligible for coverage and remain eligible, I must satisfy the eligibility requirements set forth in my employer's agreement with Health Plan, and that the information provided in this application may be relied on and used to determine my, and my dependents' (if any) eligibility for such coverage.

I agree to provide any documentation, including tax returns, payroll records, etc. necessary to establish that I, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage. I understand that Health Plan will rely on the information set forth in the application and may take any action allowed under applicable law if the statements are later found untrue, inaccurate or incomplete.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:
   a. The subscriber's spouse/DP (eligibility for a spouse ends at the end of the month in which a divorce is final or when a domestic partnership is dissolved).
   b. Any child of the subscriber, including step child, adopted child, child placed for adoption, or foster child that is under the group's age limit of 26 for dependent status.
2. Dependent children incapable of self-sustaining employment may remain under the subscriber's contract past the group's age limit of 26 for dependent status. Please complete a Coverage Request for Overage Dependent Children Form and attach it to this application.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact your Employer's Human Resources Department before signing this application.

Continued

C SIGN APPLICATION CONTINUED

Personal Information

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Heath Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to use protected health information (PHI) and history of care provided to me or my minor dependents.

I understand that Health Plan and KPIC may, without limitation and with respect to all categories of care review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by applicable federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by applicable federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy.

I further understand that to revoke this authorization I must send a written revocation notice signed by each individual over 18 years of age to:

Kaiser Foundation Heath Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, Georgia 30305.

Signature of Employee	Date
X	/ /

NON-DISCRIMINATION

Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company, Inc. (KPIC), individually and collectively, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Neither Health Plan nor KPIC exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Health Plan and KPIC, as applicable, also:

- Provide no cost aids and services to people with disabilities to communicate effectively with them, such as:
    - Qualified sign language interpreters
    - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If You need these services, call **1-888-865-5813** (TTY: 711)

If You believe that either Health Plan or KPIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: **1-888-865-5813**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

ATTENTION: If You speak English, language assistance services, free of charge, are available to You. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-888-865-5813**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-888-865-5813** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-865-5813**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-865-5813** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-865-5813** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-888-865-5813** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-865-5813** (TTY: **711**).

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