KAISER PERMANENTE®

Small Group Employee Change Form

Please print clearly in blue or black ink.

Employee Information

Last Name _____ First Name _____ MI ____

Group Number _____ Social Security Number _____

Employee Health Record Number _____ Date of Birth ____ - ____ - _____ Effective Date of Change _____

Address Change
(This section is to report a new address)

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Name Change
(This section is to be completed for name change as a result of Marriage, Divorce, or other reason)

Important:
To make a name change, please provide a Certified copy of marriage, Certified copy of record of divorce, or Certified copy of Court Order.

From: First Name _____ Last Name _____ MI ____

To: First Name _____ Last Name _____ MI ____

Change in Dependent Coverage
(This section is to be completed if you are changing (adding or dropping) coverage for eligible dependents.)

Important:
Dependent Eligibility Guidelines - To be a family dependent a person must be the subscriber's spouse or eligible dependent child under the group's age limit for dependent children.
If you are adding/dropping dependents to/from your current coverage, please check the reason for the change and fill in the appropriate dependent information below.

❑ Add dependent(s)

❑ Marriage ❑ Birth ❑ Adoption ❑ Court Order ❑ Open Enrollment ❑ Loss of Coverage

❑ Other (Explain) _____

❑ Drop dependent(s)

❑ Death ❑ Divorce ❑ Over Age Limit ❑ Other (Explain) _____

Spouse

First Name _____ Last Name _____ MI ____

Date of Birth ____ - ____ - _____ Gender ❑ Male ❑ Female Disabled ❑ Yes ❑ No

Dependent Child

First Name _____ Last Name _____ MI ____

Date of Birth ____ - ____ - _____ Gender ❑ Male ❑ Female F/T Student ❑ Yes ❑ No Disabled ❑ Yes ❑ No

Dependent Child

First Name _____ Last Name _____ MI ____

Date of Birth ____ - ____ - _____ Gender ❑ Male ❑ Female F/T Student ❑ Yes ❑ No Disabled ❑ Yes ❑ No

Dependent Child

First Name _____ Last Name _____ MI ____

Date of Birth ____ - ____ - _____ Gender ❑ Male ❑ Female F/T Student ❑ Yes ❑ No Disabled ❑ Yes ❑ No

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Kaiser Foundation Health Plan of Georgia, Inc. • P.O. Box 921012 • Fort Worth, TX 76121-1012

Termination of Subscriber (This section is to be completed if you are terminating your coverage.)	**Check reason for change:** ❑ Quit ❑ Laid off ❑ Moved out of area ❑ Enrollment change ❑ Other (Explain) _____

Please sign application on page 3

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 Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, my spouse, and 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, my spouse, and 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, my spouse's, and 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, my spouse's, 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, my spouse, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:
   a. The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.
   b. Any eligible, dependent child under the group's age limit for dependent status.
2. Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Kaiser Permanente Evidence of Coverage* or Kaiser Permanente Insurance Company Certificate of Insurance.
3. Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.
4. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Customer Service at (404) 261-2590 before signing this application.

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 review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, 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 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 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 to:

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

NOTICES:

1. I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the rescission of my coverage, as well as the coverage of my spouse and covered dependents (if any), without liability to Health Plan and/or KPIC, as applicable, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.

2. You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, GA 30305.

3. This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at *kp.org/medicalstaff*. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Customer Service at (404) 261-2590.

4. HMO plans and the Kaiser Permanente Select Provider benefit level of the Multi- Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company.

IMPORTANT: Please read the conditions above, and sign and date below. All applications MUST be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

_____	_____	_____
Signature of Employee	Date	E-mail Address (optional)