KAISER PERMANENTE®

All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Change in Ownership Form

Group number _____ Date of change in ownership _____

Company name _____

Update company name to: _____ DBA name: _____

Physical address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

Email _____

(By giving Kaiser Permanente your email address, you agree to receive email from us. Physical address must be located in the NW service area and cannot be a PO Box.)

1. PRINCIPAL OWNERS/CORPORATE OFFICERS

1. _____ _____ _____
   Name Title Tax ID

2. _____ _____ _____
   Name Title Tax ID

- Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under the Health Plan.

2. EMPLOYER SECONDARY CONTACT

A secondary contact is another person within your company or a third party (other than your producer) to whom you would like to grant account access.

☐ Check here if Secondary Contact is not authorized for group-billing-related inquires (authorized for benefit-related questions only).

_____ _____
Name Title

Email _____

Phone (_____) _____ Fax (_____) _____

3. EMPLOYER BILLING ADMINISTRATOR CONTACT

_____ _____
Name Title

Email _____

Phone (_____) _____ Fax (_____) _____

When changing the billing administrator contact, it is necessary to complete the Online Account Services User ID Request Form to access the group information online through **account.kp.org**.

4. EMPLOYER SECONDARY BILLING ADMINISTRATOR CONTACT

Name _____ Title _____

Email _____

Phone (_____) _____ Fax (_____) _____

5. EMPLOYER PHYSICAL ADDRESS

Physical address must be located in the NW service area and cannot be a PO Box.

Address _____ City _____ State _____ ZIP _____

6. EMPLOYER MAILING ADDRESS

Address _____ City _____ State _____ ZIP _____

7. EMPLOYER BILLING ADDRESS

Address _____ City _____ State _____ ZIP _____

☐ Check here if billing address is the same as mailing address.

8. AUTHORIZING SIGNATURE

Please complete, sign, and date below.

I authorize the following individual to act as the producer of record for purposes of arranging and servicing health care coverage with Kaiser Foundation Health Plan of the Northwest for the company's employees and dependents.

If you are changing the broker appointed to your account, please submit a formal broker of record letter on company letterhead.

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan of the Northwest, I agree that my company will contribute at least 50 percent of the employee-only rate, that our prepaid monthly dues will be submitted by the last day of each month prior to the month of coverage, that my company will use enrollment application forms that are provided or approved by the Health Plan, and that my company will abide by the contract provisions.

X _____ _____ _____

Employer signature Title Date

Note: Attach a copy of the bill of sale

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