

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

*This form must accompany the Washington Large Group Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Washington Large Group Employee Enrollment/Change Form.*

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name<sup>1</sup> \_\_\_\_\_ Effective date of coverage<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Group #<sup>1</sup> \_\_\_\_\_ Medical subgroup # \_\_\_\_\_ Medical billgroup \_\_\_\_\_  
Dental subgroup # \_\_\_\_\_ Dental billgroup \_\_\_\_\_

**A Employee information (Employee completes sections A, B, and C.)**

Legal name (last, first, MI)<sup>1</sup> \_\_\_\_\_  
Former/maiden name (if any) \_\_\_\_\_ Date of birth<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_  
Sex<sup>1</sup>  M  F  X  Decline to provide (at this time) Pronoun(s) \_\_\_\_\_

**B Dependent information**

Dependent (child) legal name (last, first, MI)<sup>1,2</sup> \_\_\_\_\_ Date of birth<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security # \_\_\_\_\_ Sex<sup>1</sup>  M  F  X  Decline to provide (at this time)  
Pronoun(s) \_\_\_\_\_ Mobile phone \_\_\_\_\_ Disabled  Yes  No  
 Medical  Dental Other health insurance  Yes  No  
Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_ Medical record # (if any) \_\_\_\_\_

Dependent (child) legal name (last, first, MI)<sup>1,2</sup> \_\_\_\_\_ Date of birth<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security # \_\_\_\_\_ Sex<sup>1</sup>  M  F  X  Decline to provide (at this time)  
Pronoun(s) \_\_\_\_\_ Mobile phone \_\_\_\_\_ Disabled  Yes  No  
 Medical  Dental Other health insurance  Yes  No  
Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_ Medical record # (if any) \_\_\_\_\_

Dependent (child) legal name (last, first, MI)<sup>1,2</sup> \_\_\_\_\_ Date of birth<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security # \_\_\_\_\_ Sex<sup>1</sup>  M  F  X  Decline to provide (at this time)  
Pronoun(s) \_\_\_\_\_ Mobile phone \_\_\_\_\_ Disabled  Yes  No  
 Medical  Dental Other health insurance  Yes  No  
Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_ Medical record # (if any) \_\_\_\_\_

Dependent (child) legal name (last, first, MI)<sup>1,2</sup> \_\_\_\_\_ Date of birth<sup>1</sup> \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security # \_\_\_\_\_ Sex<sup>1</sup>  M  F  X  Decline to provide (at this time)  
Pronoun(s) \_\_\_\_\_ Mobile phone \_\_\_\_\_ Disabled  Yes  No  
 Medical  Dental Other health insurance  Yes  No  
Insurance co. \_\_\_\_\_ Policy # \_\_\_\_\_ Medical record # (if any) \_\_\_\_\_

Check here if another Addendum to Washington Large Group Employee Enrollment/Change Form is attached.

**C Important**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee signature<sup>1</sup> \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<sup>1</sup>Required

<sup>2</sup>Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental disability, mental illness, or physical disability.

Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.