California Region Kaiser Permanente Group Enrollment Form

Please print or type in black ink only. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER:		
District Name: San Jose-Evergreen Community College		Hire Date (mm/dd/yyyy)
Medical Group Number: 604352	Enrollment Unit:	Effective Enrollment Date (mm/dd/yyyy) 10/01/2019

Complete this section **ONLY** if dental, vision and/or life insurance is offered through SISC:

Delta Dental Group#: N/A Vision Group#: N/A SISC Life Ins Group#: Employee Only N/A

A. ENROLLMENT: New group: Yes ☐ ☑ No

☐ New Hire (complete sections A, B, C, D) ☐ Full Time ☐ Part Time ☑ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☑ HMO Plan ☐ Deductible Plan ☑ Other

☐ Loss of Other Coverage (complete sections A, B, C, D) ☐ Other (please specify) ____

☐ Event Date (mm/dd/yyyy) ____

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known)	Social Security No.		Gender M ☐ F ☐
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)		
Home Address	City	State	ZIP
Work Phone	Home Phone	Email	
Ethnicity	Preferred Language		

C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Spouse ☐ Domestic partner Spouse/domestic partner name: Gender: Male ☐ Female ☐	☐ Med ☐ ~~Den~~ ☐ ~~Vision~~	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ ~~Den~~ ☐ ~~Vision~~	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ ~~Den~~ ☐ ~~Vision~~	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Son ☐ Daughter Dependent name:	☐ Med ☐ ~~Den~~ ☐ ~~Vision~~	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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.

Signature required for all Kaiser Permanente Plans **Date**
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

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Dependent Eligibility Documentation Chart

The following verification documents are required to enroll a dependent in health benefit plans. SISC requires the Social Security Numbers for all dependents to be covered on the plans and SISC reserves the right to request additional documentation to substantiate eligibility.

DEPENDENT TYPE	REQUIRED DOCUMENTATION
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out) • For newly married couples where the prior year tax return is not available a marriage certificate will be acceptable
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California (AB205 Compliant)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26	***Anthem Blue Cross (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form ***Kaiser (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)