# KAISER*

INSTRUCTIONS FOR CHANGE FORM

**(Remember to attach your business card and this form to your application)**

**MEMBERSHIP INFORMATION** Please complete the following information in Black Ink and include this form with your application **if the application is not legible it can not be processed**:

MEMBER NAME ______________________________

LOCAL ASSOC. NAME ______________________________

MEMBERSHIP # ______________________________

E-MAIL ADDRESS ______________________________

**CHANGING:**

[ ] Add/ Delete Dependent [ ] Change Dependent Status

[ ] Name Change [ ] Change of Address

**COMPLETING CHANGE FORM:** **USE BLACK INK AND COMPLETE BOTH PAGES**

***(DO NOT COMPLETE THE EMPLOYER SECTION***

**PLEASE FORWARD THE COMPLETED FORM:**

**U.S. MAIL:**
**ATTN: ENROLLMENT**
**Benefits Store, Inc.**
**PO Box 238, Alamo CA 94507**

**OVERNIGHT DELIVERY ONLY**
**ATTN: ENROLLMENT**
**Benefits Store, Inc.**
**85 High Eagle Road, Alamo, CA 94507-2009**

Or

**FAX:**
**ATTN: ENROLLMENT**
**(925) 855-2051**

**APPLICATION PROCESSING** Allow 12 business days for processing of your change, transmission to Kaiser and data entry before your change will appear in Kaiser's database.

**BILLING QUES.** E-Mail: **Billing@BenefitsStore.com**

*This program is a special benefit for members of local Realtor® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, The Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.



www.BenefitsStore.com
CA Insurance License No.: 0680704
Voice: (925) 855-9500 or (800) 446-2663 Fax: (925) 855-2051

# Account Change Form

KAISER PERMANENTE®

**TO BE COMPLETED BY EMPLOYER Please print or type in black ink only. Read instructions on the back. Make a copy for your records.**

Company name *(required)* ________ Date of hire *(required)* ________

Group number *(required)* ________ Enrollment unit/plan *(required)* ________ Effective date of coverage *(required)* ________

**REQUESTED CHANGE(S)**

☐ Add dependents *(Complete sections A, B, C.)* ☐ Delete dependents *(Complete sections A, B.)*

Reason ________ *(See "Change reason table.")* Event date ________

☐ Name change *(Complete sections A, B, C.)* From ________ To ________

☐ Address *(Complete Section A.)* ________

☐ Telephone *(Complete Section A.)* ________

**A. EMPLOYEE INFORMATION**

Name (Last, First, MI) ________ Medical record number ________

Home address ________ Apt. no. ________ City ________ State ________ ZIP ________

Home phone ________ Work phone ________ Social Security number ________

E-mail ________

**B. FAMILY INFORMATION** For additional dependents, please attach a separate sheet and put the employee's name at the top.

| | | |
|---|---|---|
| ☐ Spouse ☐ Domestic partner<br>Name (Last, First, MI):<br>Former last name *(if any)*: | Gender<br>☐ M ☐ F<br>Date of birth MM/DD/YY | Social Security number<br>Medical record number |
| ☐ Child ☐ Student<br>Name (Last, First, MI):<br>Relationship: | Gender<br>☐ M ☐ F<br>Date of birth MM/DD/YY | Social Security number<br>Medical record number |
| ☐ Child ☐ Student<br>Name (Last, First, MI):<br>Relationship: | Gender<br>☐ M ☐ F<br>Date of birth MM/DD/YY | Social Security number<br>Medical record number |

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

Name (Last, First, MI) ________ Address ________

**C. <u>Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement:</u>**

**I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.**

X ________

Employee signature (Use black ink.) Date

# Account Change Form

## General instructions

1. Please print legibly in black ink.
2. The employer must complete the first section labeled "To be completed by employer."
3. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect health plan premiums.
4. The employee/subscriber must complete sections A through C. See right column for detailed instructions.
5. Be sure to sign and date the bottom of the form.
6. Once the form is complete (including completed employer section), the subscriber should make a copy for his/her records.
7. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

## Instructions for completing sections

**To be completed by employer:** The employer must complete all fields to ensure we have correct account and reason information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates as these affect health plan premiums.

**Requested changes:** The subscriber must always complete this section, even when making minor changes to the account. This ensures our information is current. Please mark the box if your address or telephone number is new.

**Section A:** The subscriber must complete this section.

**Section B:** The subscriber must indicate the requested change being made to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an *overage dependent* attending school. Please contact your employer regarding the employer's rules for overage dependent students. A completed *Student Certification Form* may be required.

**Section C:** The subscriber must read and sign this section.

## Change reason table

| Add dependent reason | Event date |
|---|---|
| Acquired student status* | Date student status was obtained |
| Family adoption* | Date of adoption |
| Loss of coverage | Date coverage was lost |
| New spouse (marriage)* | Date of marriage |
| Moved into service area | Move date |
| Newborn addition | Date of birth |
| Open enrollment | Open enrollment effective date |
| **Delete dependent reason** | **Event date** |
| Loss of student status | Date of status change |
| Divorce | Date of divorce |
| Member deceased* | Date of death |
| Delete dependent(s) | Dependent termination date |
| Open enrollment | Open enrollment effective date |

*Additional documentation may be required.