California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name: **Chino Valley Unified School District** | Hire date (mm/dd/yyyy)

Group number: 228347 | Enrollment unit | Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON *(see Change Table for assistance)* New group: ❑ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

[ ] **PLAN 8 - CERT/MGMT (Active & Retiree)** [ ] **PLAN 11 - CERT/MGMT (Active & Retiree)** [ ] **HMO 20 CLASSIFIED (Active & Retiree)**

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* _____

❑ Name change *(complete sections A, B, C, D)* From: _____ To: _____

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.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) | Gender ❑ M ❑ F

Home Address | City | State | ZIP

Work Phone | Home Phone | E-mail

Ethnicity | Preferred Language

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

❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner	Gender ❑ M ❑ F	Social Security No.
Spouse/domestic partner name:		Birth Date (mm/dd/yyyy)
Former last name *(if any)*:		Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		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, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.*

Employee/Applicant signature	Date	Employer signature	Date

*Additional documentation may be required.

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