KAISER PERMANENTE®

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Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Addendum to Washington Group Employee Enrollment/Change

This form must accompany the 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 Employee Enrollment/Change Form.

This section to be completed by the employer.

Company name* ______________________ Effective date of coverage* ____ / ____ / ____

Group no.* ____________ Medical subgroup no. ____________ Dental subgroup no. ____________

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

Name *(last, first, MI)** ______________________ Former/maiden name *(if any)* ____________

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________

B Dependent information

Child name *(last, first, MI)* ______________________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ______________________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ______________________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

Child name *(last, first, MI)* ______________________ ☐ Full-time student Disabled ☐ Yes ☐ No

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no. ____________ ☐ Medical ☐ Dental

Other health insurance ☐ Yes ☐ No Insurance co. ____________ Policy no. ____________

Health record no. (if any) ____________ Medicare eligible ☐ Yes ☐ No Medicare ID no. ____________

☐ Check here if another Addendum to 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 may include imprisonment, fines, and denial of insurance benefits.

Employee signature* ______________________ Date ____ / ____ / ____

**Required*