KAISER PERMANENTE®

COBRA Enrollment Form

This enrollment form must not be submitted to Kaiser Permanente. Ask your former employer where you should send this form. Complete all fields or you may have a delay in your enrollment. Please print or type in black or dark blue ink only.

TO BE COMPLETED BY EMPLOYER

Purchaser/Enrollment Unit Number	Employer	Employer Signature/Date

Enrollment Information

Please check the reason for enrollment and complete the maximum months of coverage. ***NOTE:*** *If requesting a transfer of an existing COBRA account from another carrier to Kaiser Permanente, you must indicate the qualifying event for the initial COBRA enrollment.*

Reason for COBRA Enrollment

- ❑ Date of termination of employment: MO _____ DAY _____ YEAR _____
- ❑ Date of reduction of work hours: MO _____ DAY _____ YEAR _____
- ❑ Loss of spousal or dependent status: Effective Date of Loss: MO _____ DAY _____ YEAR _____
  Reason for loss: O Marriage O Divorce or legal separation O Death of subscriber O Reached maximum age ____
  O Subscriber's Medicare entitlement O Other _____
- ❑ Transfer of existing COBRA account from another carrier to Kaiser Permanente
  Carrier's Name & Telephone Number _____
  Policy Number _____ Policy Term Date _____
  Original initial COBRA enrollment reason _____
  Original initial COBRA coverage start date _____

Maximum months of coverage _____

Additional Enrollment Information

- ❑ Qualified beneficiary on the account is disabled pursuant to US Social Security Act
- ❑ Applying for Health Care Tax Credit (TAA/HCTC) through the Federal Government. (Please attach a copy of your potential eligibility letter.)

TO BE COMPLETED BY EMPLOYEE

Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage may be enrolled as part of your COBRA account. (Attach additional sheet, if needed.)

Subscriber Information

Name: *(Last/First/MI)*	Social Security number	Date of birth	Gender *(circle one)*
			M F

Address: *(Street/City/State/ZIP)*

Day phone number	Alternate phone number	Email address (for enrollment purpose only)

During this employment was Kaiser Permanente your group coverage? ❑ Yes ❑ No

Family Information

	Name: *(Last/First/MI)*	Role	Social Security number	Date of birth	Gender *(circle one)*
Spouse or domestic partner (if eligible)		O Spouse O Domestic partner			**M F**
Dependent		O Child O Student			**M F**
Dependent		O Child O Student			**M F**
Dependent		O Child O Student			**M F**

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the Group health plan documents, including the Evidence of Coverage. I have reviewed the statements on this form and they are true and correct. The Health Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Form.

Note: Use of binding arbitration does not apply to Kaiser Permanente Insurance Company or Out-of-Network service disputes

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*.

_____ Signature

_____ Date