KAISER PERMANENTE®

COBRA Enrollment Form

Please print or type in black or dark blue ink only. Please read the "COBRA Information Sheet" before submitting this form. Retain a copy for your records and to use as a temporary ID card if you are a new Kaiser Permanente member.

Employer Group Coverage Information

Please complete the following information so we will know about your employer's account with us. The employer from which you originally obtained COBRA should be used regardless of your current employer/employment status.

Purchaser/Enrollment Unit Number
(Your employer can provide this to you.)

Employer

Employee name *(Last/First/MI)*

Date of birth	Employee medical record number *(printed on your ID card)*

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

Enrollment Information

Please check the reason for your enrollment. ***NOTE:*** *If you are requesting a transfer of an existing COBRA account from another carrier to Kaiser Permanente, you must indicate the original reason for enrollment.*

Reason for COBRA Enrollment

❑ Termination of Employment: Last Date of Group Coverage: MO _____ DAY _____ YEAR _____

❑ Reduction of Work Hours: Last Date of Group Coverage: 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 medical 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 Enrollment Reason _____ Original Start Date _____

Additional Enrollment Information

❑ Qualified beneficiary on the account is disabled pursuant to US Social Security Act

❑ I am applying for Health Care Tax Credit (TAA/HCTC) through the Federal Government.
(Please attach a copy of your potential eligibility letter.)

Subscriber and Family Information

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	Medical record number

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

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

Family Information

	Name: *(Last/First/MI)*	Role	Social Security number	Date of birth	Gender *(circle one)*	Medical record number
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	

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 Permanente 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, 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, 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 my 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 _____