

# 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.

Company name FRESNO UNIFIED SCHOOL DISTRICT		Hire date (mm/dd/yyyy)
Group number 603815	Enrollment unit 0000 Actives	Effective enrollment/ Change Date <b>01/01/2020</b>

**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)

Health Plan (Check one)  HMO Plan  Deductible Plan  Other

**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 <input type="checkbox"/> M <input type="checkbox"/> F
Home Address	City State ZIP
Work Phone Home Phone	Email
Ethnicity	Preferred Language

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

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner Spouse/domestic partner name: Former last name (if any):	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child Dependent name: Relationship:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child Dependent name: Relationship:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

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

Name (Last, First, MI): Address:

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, Inc., Arbitration Agreement\***

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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 Required for all Kaiser Permanente Plans \_\_\_\_\_ Date \_\_\_\_\_

\*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

