Kaiser Foundation Health Plan of Georgia, Inc. **Kaiser Permanente Insurance Company**

LARGE GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM

www.kp.org/ga

Check One In Each Category:

- ❑ Enrollment Form
- ❑ Change Form

- ❑ HMO
- ❑ Added Choice POS
- ❑ Multi-Choice POS
- ❑ Out-of-Area PPO
- ❑ Out-of-Area Indemnity

Check Box:	Fill Out Sections:
❑ Open Enrollment	A, B, C, E, F, G
❑ Non-Open Enrollment	A, B, C, E, F, G
❑ COBRA Enrollment	A, B, C, E, G
❑ Conversion to Non-Group	A, B, C, E, G
❑ Add Dependent(s)	A, B, C, D, E, G
❑ Termination of Subscriber (This will remove the entire family)	A, D, G
❑ Remove Dependent(s)	A, B, C, D, E, G
❑ Change of Address	A, G
❑ Name Change	A, D, G
❑ Waive Coverage	A, F, G

To be Completed by Employer:

Effective Date

Group Number

Sub Group

Bill Group

NOTE TO NEW MEMBERS:

Save the pink copy to use as temporary identification and as a phone reference until your Kaiser Permanente I.D. Card and additional membership information arrive.

A. APPLICANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	BIRTHDATE

HOME ADDRESS	E-MAIL ADDRESS (IF ANY)	ETHNICITY (OPTIONAL)

CITY	COUNTY	STATE	ZIP CODE

COMPANY NAME	MARITAL STATUS ❑ Single ❑ Married	DATE OF MARRIAGE	DATE EMPLOYED	HOME PHONE	WORK PHONE

HEALTH/MEDICAL RECORD NUMBER	SOCIAL SECURITY NUMBER	LANGUAGE PREFERENCE
	— —	

Consumer Choice Option (CCO) ❑ Yes ❑ No If yes, an additional premium will apply. Emergency Contact: ____________ Phone ______ Relationship ________

B. COVERAGE STATUS

❑ SELF ONLY ❑ SELF & CHILD ❑ SELF & SPOUSE ❑ SELF & SPOUSE & CHILDREN ❑ SELF & CHILDREN

C. FAMILY AND PHYSICIAN INFORMATION

Please list yourself, your spouse and dependent children who you wish to be covered below. Each member enrolling for coverage, except those enrolling in the Out-of-Area PPO and Out-of-Area Indemnity plans, must select a personal physician. Please write the physician's I.D. number in the appropriate section. Refer to the Kaiser Permanente Physician Directory for the physician's I.D. number. This information is necessary to process the Enrollment Application. Each family member can choose their own personal physician. You can change your personal physician at any time—simply call our Member Services Department at **(404) 261-2590**. You can also access an updated listing of our physicians by logging on to *www.kp.org/ga.*

DEL	ADD	LAST NAME (IF DIFFERENT)	FIRST NAME	M.I.	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	RELATION-SHIP	DR.'S NAME	DR.'S I.D.	HEALTH RECORD NUMBER
								SELF			

D. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT FORM, COMPLETE THE FOLLOWING.

EFFECTIVE DATE OF CHANGE: / /

❑ Termination of subscriber. Check reason for change:
- ❑ Quit
- ❑ Enrollment change
- ❑ Laid off
- ❑ Dissatisfaction
- ❑ Moved out of area
- ❑ Other ________________

❑ Add dependent(s). Check reason for change:
- ❑ Marriage: Date __________
- ❑ Birth: Date __________
- ❑ Adoption: Date __________
- ❑ Loss of Coverage
- ❑ Other ________________

❑ Drop dependent(s). Check reason for change:
- ❑ Death: Date ________
- ❑ Divorce: Date ________
- ❑ Over Age Limit
- ❑ Other ________

❑ Name change

Previous name: ________________

Current name: ________________

Effective date: __________

E. OTHER COVERAGE INFORMATION

Your acceptance of coverage through Kaiser Permanente allows us to share the responsibility of paying for your health coverage with other group health policies that may cover you or other members of your family (such as health coverage through your spouse's employer). **This does not reduce your or your dependents' health benefits coverage from Health Plan and/or KPIC, as applicable.** In order to coordinate payment, we need the following information:

Is your spouse employed? ❑ Yes ❑ No ❑ No Spouse	If yes, spouse's employer: / Spouse's business phone number: ( )	Are you, your spouse or dependents covered under any other health insurance policy? ❑ Yes ❑ No	If yes, check who is covered: ❑ You ❑ Your Spouse ❑ Dependents

Name of group health insurance company:	Group health insurance policy number:	Are you, your spouse or dependents eligible for Medicare benefits? ❑ Yes ❑ No

F. WAIVER OF COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

❑ All coverage ❑ Coverage for my spouse ❑ Coverage for my children

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit an *Employee Enrollment Application and Change Form*, and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all appropriate boxes)
- ❑ other group coverage sponsored by my employer*
- ❑ other group coverage sponsored by my spouse's employer*
- ❑ other group coverage sponsored by another organization*
- ❑ other reasons (please explain)

* Please provide name of carrier: ________________

* Plan number:* __________ Telephone number: __________

G. SIGNATURE

I hereby apply for enrollment for myself and eligible family dependents listed above and I agree that the information listed is correct. Any material misstatement or omission of information will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information, without liability to Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan), Kaiser Permanente Insurance Company (KPIC) and The Southeast Permanente Medical Group, Inc. (Medical Group).

I understand that if the application is accepted by Health Plan and/ or KPIC, as applicable, the benefits for which we will be eligible will be in accordance with the Group Agreement and/or Group Policy applicable to the type of plan for which we are enrolled. If I am enrolling through my employer, I authorize deduction of amounts necessary to pay my Health Plan and/or KPIC coverage. I authorize Health Plan and/or KPIC, as applicable, Medical Group and/or CCN, as applicable, to provide my medical information, and the medical information (including but not limited to substance abuse, behavioral health, HIV/AIDS and confidential information) of any person included under my coverage, to each other, to other health care providers and to insurers as necessary and permitted by law, for purposes including but not limited to: underwriting and rate setting; the provision of care; conducting quality assurance, peer review or utilization review; the administration of the Agreement; and the investigation and settlement of claims. I also consent to the assignment of benefits which I may have in circumstances where a party other than Health Plan and/or KPIC may be responsible for all, or a portion of, the cost of services provided to me. These consents shall remain in force and effect for the duration of my membership in Health Plan and/or KPIC, as applicable.

This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at www.kp.org/ga. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Member Services.

Signature of Employer ____________ Signature of Applicant ____________ Date Completed ____________

This is your application for membership

Please complete the reverse side of this application and submit it to your company's personnel office. **Note to new members:** Save this pink copy to use as your temporary identification and phone reference until your Kaiser Permanente I.D. card and additional membership information arrive.

Thank you for your interest in Kaiser Permanente, the nation's health care leader for more than 55 years. We look forward to meeting your health care needs for many years to come.

MEDICAL CENTER TELEPHONE NUMBERS

Call the Health Line to make or cancel appointments, get advice or access after-hours care.

ALPHARETTA MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 663-3300
Directions to the Center (24 hours) . . . .(770) 663-3101
Health Care Operations Supervisor . . . .(770) 663-3395

CASCADE MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(404) 505-4071
Directions to the Center (24 hours) . . . .(404) 505-4001
Health Care Operations Supervisor . . . .(404) 505-4012

CRESCENT MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 496-3523
Directions to the Center (24 hours) . . . .(770) 496-3401
Health Care Operations Supervisor . . . .(770) 496-3533

CUMBERLAND MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 431-4136
Directions to the Center (24 hours) . . . .(770) 431-4550
Health Care Operations Supervisor . . . .(770) 431-4232

EASTSIDE MEDICAL OFFICE

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Directions to the Office (24 hours) . . . .(770) 982-7594

GLENLAKE MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 677-6000
Directions to the Center (24 hours) . . . .(770) 677-5801
Health Care Operations Supervisor . . . .(770) 677-6043

HENRY TOWNE CENTRE MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(678) 583-6560
Directions to the Center (24 hours) . . . .(678) 583-6618
Health Care Operations Supervisor . . . .(678) 583-6610

MEDICAL CENTER AT GWINNETT

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 931-6134
Directions to the Center (24 hours) . . . .(770) 931-6001
Health Care Operations Supervisor . . . .(770) 931-6026

PANOLA MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 322-2737
Directions to the Center (24 hours) . . . .(770) 322-2701
Health Care Operations Supervisor . . . .(770) 322-3238

SOUTHWOOD MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 603-3511
Directions to the Center (24 hours) . . . .(770) 603-3690
Health Care Operations Supervisor . . . .(770) 603-3647

TOWNPARK MEDICAL CENTER

Health Line Locally . . . .(404) 365-0966
Long Distance .1-800-611-1811
Prescription Refills (24 hours) . . . .(770) 434-2008
Pharmacy . . . .(770) 514-5500
Directions to the Center (24 hours) . . . .(770) 514-5566
Health Care Operations Supervisor . . . .(770) 514-5405

EMERGENCY CARE

If you have an emergency, call 911 or go to the nearest emergency room. An emergency is any sudden, severe illness or injury that jeopardizes life or health and that would lead a reasonable person with no medical training to seek immediate medical attention. For follow-up care, call us at (404) 365-0966 locally or 1-800-611-1811 long distance.

MEMBER CONFIDENTIALITY

Kaiser Permanente collects various types of nonpublic personal information, including information contained in your health records, personally identifiable information, and financial information. Such nonpublic personal information may be collected from you and other sources in order to provide health care services, customer services, evaluate benefits and claims, administer health care coverage, and fulfill legal and regulatory requirements, among other things.

Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of nonpublic personal information, including policies related to access to medical records.

Kaiser Permanente may collect, use and share nonpublic personal information when medically necessary or for other purposes as permitted or required by law. Nonpublic personal information will not be released to third parties including your employer, researchers, or the government without your or your authorized representative's consent, except as may be permitted or required by law.

All Kaiser Permanente employees and physicians are required to maintain the confidentiality of our Members' nonpublic personal information. This obligation is addressed in policies, procedures, confidentiality agreements and Principles of Responsibilities. All providers with whom we contract are also required to maintain confidentiality.

You may request, in writing, to inspect your own medical record. You may request a copy of your medical record as allowed by law. There may be a fee for copies provided to you. You may also request, in writing, to amend information in your medical record to enhance its completeness and accuracy. Original medical record documentation will not be deleted, however. Your request to review or amend your medical records should be submitted to the medical record department located in the medical facility that you regularly visit.

If you have questions about our policies and procedures to maintain the confidentiality of nonpublic personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses nonpublic personal information, please call our Member Services Department, Monday through Friday from 8:30 a.m. to 9 p.m., and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590.

KAISER PERMANENTE®