KAISER PERMANENTE®

COBRA or Cal-COBRA Enrollment Form

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

Employer Group Coverage Information

Please complete the following information about the employer account your group coverage was with.

Purchaser/Enrollment Unit Number*: __________________----___________
Employer Name____
During this employment, was coverage provided by Kaiser Permanente? ____Yes ____No
If yes, who was the subscriber on the account? Last Name______________________ First Name __________________ MI _____
Medical Record Number ____________________________ Date of Birth__________________________________
*Check with your former employer if you do not know the Purchaser/Enrollment Unit number.

Reason for COBRA or Cal-COBRA Enrollment

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

___**Temination of Employment** (18 month coverage) Last Date Employed: mo_______ date_________ yr_________
___**Reduction of Work Hours** (18 month coverage) Last Date of Group Coverage: mo________ date________ yr________
___**Loss of dependent status** (36 month coverage) Effective Date of Loss: mo_________ date ________ yr_________
Reason for loss: __ Marriage __ Divorce __ Death of subscriber __ Reached maximum age __ Other ___________________
___**Disabled per Social Security** (29 month coverage) Last Date Employed: mo_____ date________ yr_________
(Social Security Administration letter is required for disability status)

Existing COBRA or Cal-COBRA Account Information

Please complete the following *only* if you already have an existing COBRA account with another health plan carrier.

Carrier's Name_______________________________________ Policy Number ____________________________
End date of current COBRA or Cal-COBRA account: mo_________ date_________ yr__________

COBRA or Cal-COBRA Enrollment Information

Please list all members to be enrolled in the account. Except in case of annual Open Enrollment, or Special Enrollments due to HIPAA, only dependents included in the prior group coverage may be enrolled as part of your COBRA or Cal-COBRA account.
(Attach additional sheet if needed.)

	Last Name	First Name	MI	Role	SSN	Date of Birth	Gender	Medical Record Number
Subscriber				Subscriber			__M __F	
Spouse				___ spouse ___ domestic partner			__M __F	
Dependent				___ child ___ student			__M __F	
Dependent				___ child ___ student			__M __F	
Dependent				___ child ___ student			__M __F	
Dependent				___ child ___ student			__M __F	
Dependent				___ child ___ student			__M __F	

Your Address:____
Your Phone: Day______________________________ Evening ______________________________

I understand, that except for Small Claims Court cases, 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 relating to membership in Health Plan (which provides HMO and In-Network Point-of-Service benefits), 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 a 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 arbitration provision is contained in the *Evidence of Coverage* and does not apply to disputes with Kaiser Permanente Insurance Company or disputes arising from Out-of-Network services.
Note: A different arbitration provision applies for Federal Employees Health Benefits Program and CalPERS groups. Please contact Member Services for the applicable arbitration provision.

Signature ____ Date ______________________

Top copy-To Membership Accounting **Middle copy**-To be retained by the group **Bottom copy**-To be retained by the subscriber

Tips for Completing this Form
Use these guidelines for completing the enrollment form. Be sure to read the Information Sheet provided with this form. If you did not receive an information sheet, please check with your former employer or contact our Member Services Call Center at **1-800-464-4000**.

1. Complete all applicable fields on the form. Use only dark blue or black ink. Please print clearly.

2. Complete and sign this enrollment form. Include information on all dependents to be covered. We do not automatically transfer members from an employer group account to a COBRA or Cal-COBRA account.

3. The subscriber on the group coverage account is not required to be enrolled in the COBRA or Cal-COBRA account. Please specify who the subscriber on the account should be in the "COBRA or Cal-COBRA Enrollment Information" section of the form.

4. To be eligible, a dependent must have been covered under your group plan. The only exception to this is if you are transferring your existing COBRA or Cal-COBRA account to Kaiser Permanente, are making a new election at Open Enrollment, or are enrolling new dependents under the special enrollment provisions of HIPAA.

5. For enrollment in a COBRA account, obtain the applicable Health Plan dues rate from your personnel or Human Resources department. Kaiser Permanente will provide you rate information on Cal-COBRA accounts.

6. Do not submit payment with this form. If enrolling in a Kaiser Permanente administered COBRA account, you will receive an invoice once your enrollment is processed. If enrolling in a group administered COBRA account, your former employer will instruct you on how to make your payments.

7. If enrolling in Cal-COBRA, mail or fax (not both) the completed form to the address provided below.

8. For enrollment in a COBRA account, check with your former employer as to where to submit the form.

9. Be sure to include the Medical Record Numbers of any members who are, or ever have been, Kaiser Permanente members. It is very important that members retain their Medical Record Numbers.

10. Only new members will receive an ID card. Existing members **will not** receive new cards. Continue to use your existing card.

11. If you are transferring your existing COBRA account from another carrier to Kaiser Permanente during open enrollment, be sure to tell us the original reason for your COBRA coverage, and identify your other carrier's name and your end or exhaustion date.

Use the information below only if you are enrolling in a Cal-COBRA account or if instructed by your former employer for a COBRA account.

<u>Mailing Address</u>
Kaiser Permanente
PO Box 23127
San Diego, CA 92193

<u>Fax Numbers</u>
Southern California Accounts, 1-858-614-3345
Northern California Accounts, 1-858-614-3344

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COBRA or Cal-COBRA Account Enrollment Form

Please read instructions and complete form to request enrollment in a Kaiser Permanente COBRA or Cal-COBRA account.

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