

Please print or type in black ink only. See instructions on reverse *before* completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER			
Company name	COUNTY OF SANTA BARBARA	Hire date (mm/dd/yyyy)	
Group number	229297	Enrollment unit	Effective enrollment or coverage date (mm/dd/yyyy)

NEW ENROLLMENT *Check one:*

<input type="checkbox"/> New hire (complete sections A, B, C, D)	<input type="checkbox"/> Other coverage loss (complete sections A, B, C, D)
<input type="checkbox"/> Open enrollment (complete sections A, B, C, D)	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> New group	Event date (mm/dd/yyyy) _____

PLAN *Check one:* HMO **---- LOW OPTION** **---- HIGH OPTION**

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

<input type="checkbox"/> Add dependents (complete sections A, B, D)	<input type="checkbox"/> Delete dependents (complete sections A, B, D)	Event date (mm/dd/yyyy)
*Reason: (see Change Table)		
<input type="checkbox"/> Name change (complete sections A, B, D) From: _____ To: _____		
<input type="checkbox"/> Address change (complete section A) <input type="checkbox"/> Telephone change (complete section A)		

A. EMPLOYEE

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	Apt. no.	City	State ZIP
Work phone	Home phone	E-mail	
Preferred spoken or written language		Ethnicity	

B. 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	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.
Spouse/domestic partner name:		Birth date (mm/dd/yyyy)
Former last name (if any):		Medical record no.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.
Dependent name:		Birth date (mm/dd/yyyy)
Relationship:		Medical record no.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.
Dependent name:		Birth date (mm/dd/yyyy)
Relationship:		Medical record no.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.
Dependent name:		Birth date (mm/dd/yyyy)
Relationship:		Medical record no.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no.
Dependent name:		Birth date (mm/dd/yyyy)
Relationship:		Medical record no.

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

Name (Last, First, MI):	Address:
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C. OTHER COVERAGE Including yourself, do any of the persons listed above have other coverage? Yes No

Name	Insurance carrier name	Policy no./Effective date	Phone no.
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D. 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*.

Employee/Applicant signature	Date	Employer signature	Date
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