KAISER PERMANENTE® DELTA DENTAL®

2024 Employee enrollment and change form

Return completed form to Kaiser Permanente, P.O. Box 23219, San Diego, CA 92193-9921

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Effective date_____

Termination date _____

Group name_____

Group number_____

Selected health plan _____

Pay location (if applicable)_____

Original date of hire ____/____/____

Date of rehire ____/____/____

Date transferred from part time (p/t) to full time (f/t) ____/____/____

Hours worked per week _____

If retired, date of retirement ____/____/____

Choose one:

☐ Open enrollment ☐ Add dependent(s)

☐ New employee ☐ Remove coverage

☐ Address/name change ___ Employee ___ Dependent(s)

☐ Qualifying event _____

Date processed ____/____/____ by _____

☐ **Transfer to COBRA**

Start date ___/___/___

☐ 18 months

☐ 36 months

Waive Delta Dental

☐ I elect to waive dental

Reminder to employers: For groups already enrolled in direct policies, enrollment and changes can be made online via our Business Portal.

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Mobile phone* (_____)_____
(Last name) (First name) (M.I.)

Resident address _____ Home phone* (_____)_____
(Street) (City) (State) (ZIP)

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse/domestic partner (if applicable) _____

* I understand that Kaiser Permanente may contact me via email or text messaging.

For health plan internal use only	Check one		Please print Last name First name M.I.	Social Security number	Male/ Female	Birthdate (MM/DD/YY)	Relationship to employee
	Add	Remove					
			Self **(unless waived, dental coverage will apply to all enrolled members of a family)**				
			Spouse/domestic partner/dependent (circle one)				
			Dependent				
			Dependent				
			Dependent				

_____
(Signature of employee) (Date signed)

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. In Washington state, a registered domestic partner is treated the same as a spouse. If children of the primary insured are covered, children of a domestic partner are eligible for coverage on the same basis. Dental enrollment will mirror enrollment in medical unless waived by the entire family. All health plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057. Optional dental offered by Delta Dental of Washington, 400 Fairview Ave N., Suite #800, Seattle, WA 98109.