KAISER PERMANENTE®

Kaiser Permanente Student Health Plan Enrollment/Change Form

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Name:____ Student ID:___________________________

When to use this form:

1. When enrolling during your school's Open Enrollment period (only if you do not have access to online enrollment via **studentnet.org** and/or you've been instructed to do so by your school administrator).
2. When enrolling during your school's late add/drop period when online enrollment is not available.
3. When making changes anytime during the academic year to:
   - Terminate your coverage in the event of active military service.
   - Add or update dependent information.
   - Update contact information.
   - Enroll mid-year if you have lost coverage through another carrier as specified in your *Evidence of Coverage (EOC)*.

If you have Medicare Part A or B, you do not qualify for the Student Health Plan. Please visit **kp.org** and select a plan that's right for you.

General Instructions and Guidelines:

1. Please print firmly and legibly in black ink.
2. Your school administrator is responsible for completing the section titled "To be completed by school administrator" and for confirming all information submitted by you, especially effective dates, as these affect your Student Health Plan dues.
3. Complete sections B, C (if you want to enroll dependents), D, E, and F. If you're making a change, please also mark the appropriate box in Section A. (All changes to accounts, including effective dates, will be made in accordance with the school's contractual agreements with Kaiser Foundation Health Plan, Inc.)
4. Once the form is complete (including the school administrator section), make a copy for your records and use it as a temporary Kaiser Permanente ID card after the effective date and until you receive your permanent ID card and plan information in the mail.
5. Sign and date Sections E and F at the bottom of the form.
6. Submit the completed form to your school administrator.

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Name:____ Student ID:____________________________

TO BE COMPLETED BY SCHOOL ADMINISTRATOR

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School Name ____________________ Customer ID Number ____________________ Enrollment unit ____________________

Effective Date (mm/dd/yyyy) ____________________ Academic Year ____________________

TO BE COMPLETED BY STUDENT

A. MAKE A CHANGE (Required if making a change.)

Check those that apply:

❑ Terminate coverage for active military service Date of deployment_________________________________

❑ Add or update dependent information midterm. Enter dependent information in Section C.
❑ Update your contact information midterm. Enter new information in Section B.
❑ Add coverage mid-term due to loss of coverage from another carrier. Complete Sections B, C (if you want to enroll dependents), D, E, and F.

B. STUDENT INFORMATION

Health Plan (Check one) ❑ HMO ❑ Deductible HMO ❑ HMO with Added Coverage

Have you ever been a Kaiser Permanente member? (new enrollees only) ❑ Yes ❑ No

Medical Record Number *(if known)* ____________________ Student Identification Number ____________________

Birth date (mm/dd/yyyy) ____________________ Gender ❑ M ❑ F

Name (Last, First MI) ____________________

Street address ____________________ Apt. No. ________ City ____________________ State ________ ZIP ________

Please give the address of your place of residence while at school (if known). This address will be used to mail your Kaiser Permanente ID card and other important Health Plan information.

Cell Phone ____________________ Home Phone ____________________

E-mail Address ____________________ Preferred Language ____________________

Ethnicity ____________________

C. DEPENDENTS

To enroll dependents, you must indicate the requested change to the account and complete all fields. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last name of your spouse or domestic partner. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your school administrator regarding rules for overage dependent students. A completed *Student Certification* form may be required.

For additional dependents, attach a separate sheet with your name at the top. (Last, First MI)

❑ Add ❑ Delete ❑ Spouse ❑ Domestic Partner Gender ❑ M ❑ F Social Security Number______________________
Spouse/domestic partner name____ Birth Date (mm/dd/yyyy) ______________________
Former last name *(if any)*____ Medical Record Number *(if known)*____________

❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Social Security Number______________________
Dependent name____ Birth Date (mm/dd/yyyy) ______________________
Relationship____ Medical Record Number *(if known)*____________

❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Social Security Number______________________
Dependent name____ Birth date (mm/dd/yyyy) ______________________
Relationship____ Medical Record Number *(if known)*____________

❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Social Security Number______________________
Dependent name____ Birth Date (mm/dd/yyyy) ______________________
Relationship____ Medical Record Number *(if known)*____________

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TO BE COMPLETED BY STUDENT

C. DEPENDENTS (continued)

Do any of the above dependents live at another address? ❑ Yes ❑ No If yes, complete the following:
For an additional dependent, who lives at another address, please use the space below. If you have more than one additional dependent, please attach a separate sheet with your name at the top (Last, First MI) and the dependents' names (Last, First MI) and addresses.

Name (Last, First MI)____ Address____

D. ELECT COVERAGE (required)

Be sure to review your school's rate, coverage dates, and break date information (if applicable) at **studentnet.kp.org** before checking the box in this section.

❑ By checking this box, you are electing coverage beginning with the current school term through the end of the academic year. You are also acknowledging that you have reviewed the coverage dates, rates, and break dates (if applicable) for your school at StudentNet (**studentnet.kp.org**). Coverage will continue through the end of the academic year unless you actively waive coverage, fail to pay your premiums, or terminate coverage. You are required to re-enroll in the Student Health Plan once per academic year.

E. AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Kaiser Foundation Health Plan, Inc. to disclose to an authorized representative of my school information about my enrollment or disenrollment in, and my payment of premiums for, Student Health Plan. My school may use this protected health information (PHI) only for the purpose of verifying:

(i) My enrollment in, or disenrollment from, Student Health Plan; and
(ii) My payment of premiums for Student Health Plan.

I understand that my eligibility for membership in Student Health Plan is based in part on my school's verification of my status as an enrolled student eligible to participate in Student Health Plan and a requirement of eligibility is to provide the above authorization. If I do not provide the authorization, I understand that I will be unable to enroll in Student Health Plan.

DURATION: The above authorization shall become effective immediately and shall remain in effect for one year from the date of my signature below unless a different date is specified here: _______________

REVOCATION: This authorization is also subject to written revocation by me at any time. The written revocation will be effective upon my request, except to the extent that the disclosing party or others have acted in reliance upon this authorization before my revocation.

REDISCLOSURE: I understand that the recipient of my PHI may not lawfully further use or disclose it unless:

(i) Another authorization is obtained from me, or
(ii) Such use or disclosure is specifically required or permitted by law.

I understand, however, that any PHI disclosed in reliance upon this authorization that is further redisclosed may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

____ _____________________________
Printed name Date

____
Signature

If this form is to be signed by anyone other than the individual (student) who is the subject of the information to be disclosed, the individual who signs must provide all the information requested below.

❑ I am authorized to sign the authorization on behalf of the student/subscriber.

____ ____
Printed name Date

____ ____
Signature Relationship

F. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.

____ _____________________________________
Signature Required Date

By signing this Kaiser Permanente Student Health Plan Enrollment/Change Form *in Section F, I agree that I have reviewed and understand my school's Student Health Plan rates and coverage dates (and break date information, if applicable) at my school's StudentNet Web site (**studentnet.kp.org**).*