## California Region Kaiser Permanente Group Enrollment Form

Please print or type in black ink only. Make a copy for your records.

District Name:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)	KINGSBURG JOINT UNION HS DISTRICT    Hire Date (mm/dd/yyyy)		TO BE COMPLETED BY EMPLOYER.			
Hire Date (mm/dd/yyyy)   Medical Group Number:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)	Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  ENROLLMENT:  New group: Yes   No  New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)  Realth Plan (Check one)   HMO Plan   Deductible Plan   Other  Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  Edical Record No. (if known)  Social Security No.   Gender M   Full First, MI)  Deme Address   City   State   ZIP  Ork Phone   Home Phone   Email  Inhicity   Preferred Language  FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)			C DICTRICT		
Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:	Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:	District Name: KINGSBURG JOIN I UNION HS DISTRICT	District Name: KINGSBURG JOINT UNION H	S DISTRICT	Hire Date (mm/dd/yyyy)	
Delta Dental Group#:	Delta Dental Group#:	District Name.	Medical Group Number: Enrol	lment Unit:		e
New group: Yes   No   New group: Yes   No   New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)   HMO Plan   Deductible Plan   Other   Other   Other (please specify)   Devent Date (mm/dd/yyyy)   Other (please specify)   Other (please	ENROLLMENT:    New group: Yes   No   No   New group: Yes   No   No   New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)   No   No   No   No   No   No   No   N	Medical Group Number: Enrollment Unit: Effective Enrollment Date	Complete this section <b>ONLY</b> if dental, vision and/or life insurance	e is offered through SISC:	·	
New group: Yes   No   New group: Yes   No   New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)   HMO Plan   Deductible Plan   Other   Other   Other (please specify)   Devent Date (mm/dd/yyyy)   Other (please specify)   Other (please	ENROLLMENT:    New group: Yes   No   No   New group: Yes   No   No   New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)   No   No   No   No   No   No   No   N	Medical Group Number: Enrollment Unit: Effective Enrollment Date (mm/dd/yyyy)			Ins Group#: Employee Only	
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Health Plan (Check one)	Hade   Plan   Check one   HMO   Plan   Deductible Plan   Other     Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)     Event Date (mm/dd/yyyy)   EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No     Redical Record No. (if known)   Social Security No.   Gender M   Ference   Family     Social Security No.   Gender M   Ference   Family     State   ZIP     State   ZIP     State   Tip     State	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only			roup: Yes 🔲 🔲 No	
B. EMPLOYEE: Have you ever been a Kaiser Permanente member? Yes No  Medical Record No. (if known) Social Security No. Gender M Name (Last, First, MI) Birth Date (mm/dd/yyyy)  Home Address City State ZIF Work Phone Home Phone Email  Ethnicity Preferred Language  C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)  Add Spouse Domestic partner Med Den Vision Social Security No. Birth Date (mm/dd/yyyy)	EMPLOYEE: Have you ever been a Kaiser Permanente member?  Yes No  edical Record No. (if known)  Social Security No.  Gender M F ame (Last, First, MI)  One Address  City  State  ZIP  ork Phone  Home Phone  Email  hnicity  Preferred Language  FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  New group: Yes  No	New Hire (complete sections A, B, C, D) ☐ Full Time ☐ PHealth Plan (Check one) ☐ HMO Plan ☐ Deductible F	art Time [ Plan	Open Enrollment (complete se	ections A, B, C, D)
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Medical Record No. (if known)   Social Security No.   Gender M     Name (Last, First, MI)   Birth Date (mm/dd/yyyy)     Home Address   City   State   ZIF     Work Phone   Home Phone   Email     Ethnicity   Preferred Language     C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)     Add	edical Record No. (if known)  Social Security No.  Gender M  F  ame (Last, First, MI)  Dense Address  City  State  ZIP  Ork Phone  Home Phone  Email  hnicity  Preferred Language  FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  A. ENROLLMENT:  New group: Yes  No  New group: Yes  Open Enrollment (complete sections A, B, C, D)  Health Plan (Check one)			/	
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Spouse/domestic/j.æg ^\j/j.æ ^K Birth Date (mm/dd/yyyy)		Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  A. ENROLLMENT:  New group: Yes				
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	Birth Date (mm/dd/yyyy)  Medical Record No.  Add Son Daughter  Ependent name:  Med Den Vision  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  A. ENROLLMENT:  New group: Yes   No  New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)  Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)  Event Date (mm/dd/yyyy)  B. EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  Medical Record No. (if known)  Social Security No.  Birth Date (mm/dd/yyyy)  Home Address  City   State   ZIP  Work Phone   Home Phone   Email  Ethnicity   Preferred Language  C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)  Add   Spouse   Domestic partner   Med   Den   Vision   Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)	□ Add □ Son □ □ Doughtor			
	Birth Date (mm/dd/yyyy)  Medical Record No.  Add Son Daughter  Ependent name:  Med Den Vision  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.	Medical Group Number:   Enrollment Unit:   Effective Enrollment Date   (mm/dd/yyyy)			•	
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Name (Last, First, MI):  D. Kaiser Foundation Health Plan Arbitration Agreement	Birth Date (mm/dd/yyyy)  Medical Record No.  Add Son Daughter Med Den Vision  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Address:  Kaiser Foundation Health Plan Arbitration Agreement	Medical Group Number:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)				
Name (Last, First, MI):  D. Kaiser Foundation Health Plan Arbitration Agreement I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure	Birth Date (mm/dd/yyyy)  Medical Record No.  Add Son Daughter Med Den Vision Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Address:  Maiser Foundation Health Plan Arbitration Agreement  Inderstand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure	Medical Group Number:				
Name (Last, First, MI):  D. Kaiser Foundation Health Plan Arbitration Agreement I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedur regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs	Birth Date (mm/dd/yyyy)  Medical Record No.  Add Son Daughter Med Den Vision  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Social Security No.  Birth Date (mm/dd/yyyy)  Medical Record No.  Birth Date (mm/	Medical Group Number:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)				
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Spouse/domestic/j æg ^l/j æg ^K  Birth Date (mm/dd/yyyy)	Add L I Snouge I I Domestic partner L Mod E Don El/(ision I Social Security No	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  A. ENROLLMENT:  New group: Yes  No  New Hire (complete sections A, B, C, D) Full Time Part Time Open Enrollment (complete sections A, B, C, D)  Health Plan (Check one) HMO Plan Deductible Plan Other  Loss of Other Coverage (complete sections A, B, C, D) Other (please specify)  Event Date (mm/dd/yyyy)  B. EMPLOYEE: Have you ever been a Kaiser Permanente member? Yes No  Medical Record No. (if known)  Social Security No.  Medical Record No. (if known)  Birth Date (mm/dd/yyyy)  Home Address  City  State  ZIP  Work Phone  Home Phone  Email  Ethnicity				Т
Spouse/domestic/j æg ^l/j æg ^K  Birth Date (mm/dd/yyyy)	Add Spouse Domestic partner SMad Don DVision Social Security No.	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC: Delta Dental Group#:  Vision Group#:  New group:  New group: Yes No  New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)   Halth Plan (Check one)   HMO Plan   Deductible Plan   Other   Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)   Event Date (mm/dd/yyyy)  B. EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes No  Medical Record No. (if known)   Social Security No.   Gender M   Full Plan   Full P	C. FAMILY For additional dependents attach a separate she	eet with employee's name at top.	(Last, First, MI)	
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□ Loss of Other Coverage (complete sections A, B, C, D) □ Other (please specify) □ Event Date (mm/dd/yyyy) □ Pother (please specify) □ Pother (plea	Loss of Other Coverage (complete sections A, B, C, D) Other (please specify)    Event Date (mm/dd/yyyy)	Medical Group Number:  Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only	New Hire (complete sections A, B, C, D) ☐ Full Time ☐ P	art Time	Open Enrollment (complete se	ections A, B, C, D)
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New Hire (complete sections A, B, C, D)	New Hire (complete sections A, B, C, D)	Medical Group Number: Enrollment Unit: Effective Enrollment Date			Ins Group#: Employee Only	
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Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)	Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC: Delta Dental Group#:	District Name: KINGSBURG JOINT UNION HS DISTRICT   Hire Date (mm/dd/sssss)	District Name: KINGSBURG JOINT UNION H	S DISTRICT	Hire Date (mm/dd/yyyy)	
Hire Date (mm/dd/yyyy)   Medical Group Number:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)	Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  ENROLLMENT:  New group: Yes   No  New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)  Realth Plan (Check one)   HMO Plan   Deductible Plan   Other  Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  Edical Record No. (if known)  Social Security No.   Gender M   Full First, MI)  Deme Address   City   State   ZIP  Ork Phone   Home Phone   Email  Inhicity   Preferred Language  FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)	IZINGODUDO TOINIT LINIONI LIO DIOTDIOT	TO BE GOING ELTED BY EING EGTER.			
Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:	Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:	District Name: KINGSBURG JOINT UNION ITS DISTRICT	District Name:	3 DISTRICT	Hire Date (mm/dd/yyyy)	
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Hire Date (mm/dd/yyyy)   Medical Group Number:   Enrollment Unit:   Effective Enrollment Date (mm/dd/yyyy)	Enrollment Unit:  Effective Enrollment Date (mm/dd/yyyy)  Complete this section ONLY if dental, vision and/or life insurance is offered through SISC:  Delta Dental Group#:  Vision Group#:  SISC Life Ins Group#: Employee Only  ENROLLMENT:  New group: Yes   No  New Hire (complete sections A, B, C, D)   Full Time   Part Time   Open Enrollment (complete sections A, B, C, D)  Realth Plan (Check one)   HMO Plan   Deductible Plan   Other  Loss of Other Coverage (complete sections A, B, C, D)   Other (please specify)  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  EMPLOYEE: Have you ever been a Kaiser Permanente member?   Yes   No  Edical Record No. (if known)  Social Security No.   Gender M   Full First, MI)  Deme Address   City   State   ZIP  Ork Phone   Home Phone   Email  Inhicity   Preferred Language  FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)	MINIOCOLUDO, IOINIT LINUONI LIO DIOTDIOT	TO BE COMPLETED BY EMPLOYER:			
District Name: KINGSBURG JOINT UNION HS DISTRICT	KINGSBURG JOINT UNION HS DISTRICT    Hire Date (mm/dd/yyyy)					

\*Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration1) the Preferred Provider Organization (PPO) and the

Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

KAISER PERMANENTE®