California Region Kaiser Permanente Group Enrollment Form

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

TO BE COMPLETED BY EMPLOYER:		
District Name:		Hire 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)

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.	Gender M ☐ F ☐
Name (Last, First, MI)	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

Spouse/domestic

☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐

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

Name (Last, First, MI): Address:

KAISER PERMANENTE