

When to use this form:

1. To enroll during Open Enrollment (only if instructed to by your school administrator)
2. To enroll during your school's late add/drop period when online enrollment is not available
3. To make changes anytime during the academic year to:
 - terminate your coverage in the event of active military service
 - add, delete, 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 (Health Plan). Please visit kp.org and select a plan that is right for you.

General Instructions and Guidelines:

1. Please print firmly and legibly in black ink.
2. The school administrator is responsible for completing the first section titled "To be completed by school administrator" and for confirming all information submitted by the student, especially effective dates, as these affect the student's Health Plan dues.
3. Complete Sections B, C (if you want to enroll dependents), D, and F. Section E is optional. 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 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 the bottom of the form.
6. Submit the completed form to your school administrator.

Specific instructions for each section:

"To be completed by school administrator" section: The school administrator must complete all fields in this section to ensure Kaiser Permanente has the correct account and enrollment information.

"To be completed by student" section:

- **Section A:** Please mark the appropriate box in Section A if you are using this form to make a change.
- **Section B:** You must complete Section B.
- **Section C:** For any dependents being enrolled, 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 names for both spouses and dependents. 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.
- **Section D:** You must complete Section D. 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.
- **Section E:** Section E is optional; however, if you do not complete Section E, your school may not be able to enroll you in the Plan.
- **Section F:** You must sign and date the form in Section F.

TO BE COMPLETED BY SCHOOL ADMINISTRATOR_____
School Name_____
Customer ID Number_____
Effective Date (mm/dd/yyyy)

A. MAKE A CHANGE

Check those that apply:

- Terminate coverage for active military service Date of deployment _____
From _____ To _____
- Add, delete, or update dependent information mid-term. Enter dependent information in Section C.
- Update your contact information mid-term. Enter new information in Section B.
- Add coverage mid-term due to loss of coverage from another carrier. Complete Sections B through F.

B. STUDENT INFORMATION

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

Medical Record Number (if known) _____ Student Identification Number _____

Name (Last, First, MI) _____

Street address _____ Apt. No. _____ City _____ State _____ ZIP _____

Please give your school address 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

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

Add Delete Spouse 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 Gender M F Social Security Number _____
 Dependent name _____ Birth Date (mm/dd/yyyy) _____
 Relationship _____ Medical Record Number (if known) _____

Add Delete Child Gender M F Social Security Number _____
 Dependent name _____ Birth date (mm/dd/yyyy) _____
 Relationship _____ Medical Record Number (if known) _____

Add Delete Child Gender M F Social Security Number _____
 Dependent name _____ Birth Date (mm/dd/yyyy) _____
 Relationship _____ Medical Record Number (if known) _____

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

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

Name (Last, First, MI) _____ Address _____

TO BE COMPLETED BY STUDENT

D. ELECT COVERAGE

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. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AUTHORIZATION

I authorize Kaiser Foundation Health Plan, Inc., to disclose information about my enrollment, disenrollment, and information about my payment of premiums for the plan to the designated representative of my school. This authorization allows my protected health information to be disclosed to my designated representative only for verifying enrollment in, disenrollment from, and payment of premiums for the Student Health Plan.

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____

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

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that:

1. Personal health information (PHI) disclosed in reliance on this authorization may be redisclosed and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.
2. I have the right to revoke this authorization. If I choose to do so, I must send a written revocation of this authorization to Kaiser Foundation Health Plan, Inc., and my designated representative will no longer use or disclose my PHI, except to the extent Kaiser Foundation Health Plan, Inc., or my designated representative has taken action in reliance upon this authorization.
3. This authorization is voluntary. I have made this request for release of my PHI to my designated representative.

Printed name _____ Date _____

Signature _____

If a personal representative of the student/subscriber executes this form, that personal representative must show with appropriate documents that he or she has authority to sign the form on the basis of:

- Legal authority (power of attorney, etc.)
- Parent or guardian status, or other individual acting in loco parentis
- Written designation by the student/subscriber

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

Date Signature Relationship (if signed by anyone other than student)

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 a group that is subject to ERISA, 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 *Membership Agreement* and in the *Certificate of Insurance*.

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).

TO BE COMPLETED BY STUDENT