

Plan Selected
Kaiser Hospital Deduc HMO
 500/20/10%
 1000/30
Check One

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION		FOR PIBT USE ONLY
Company Name	Phone ()	
Address		GROUP #
New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Other <input type="checkbox"/> <i>Changes (Check appropriate boxes)</i> <input type="checkbox"/> Add dependent(s) - List information in Section 4 <input type="checkbox"/> Drop employee or dependent(s) - List those being deleted in Section 4 <input type="checkbox"/> Address change - Complete Section 3 <input type="checkbox"/> Name change - Complete Sections 3 and 4		Additions, Terminations or Changes of Coverage: Report all additions, terminations or changes of group coverage to Printing Industries Benefit Trust no later than the 20th day of the month in which it is effective. COVERAGE EFFECTIVE DATE PIBT ACCOUNT NO.

SECTION 2 LIFE INSURANCE BENEFICIARY INFORMATION			
Life Beneficiary (Full Name)	Address (if different)	Relationship	Must equal 100% %
Life Beneficiary (Full Name)	Address (if different)	Relationship	%

SECTION 3 EMPLOYEE INFORMATION						
Last Name	First Name	M.I.			<input type="checkbox"/> Single <input type="checkbox"/> Married <i>Date of Marriage</i> _____ <input type="checkbox"/> Domestic Partner <i>Registration Date</i> _____	
Social Security Number	Full Time Hire Date	Employment Status	Job Title			
		<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly				
Residence Mailing Address (Number, Street, Apartment)			City	State	Zip	
Home Telephone ()	Mobile Phone Number ()	Have you or any of your dependents ever been a Kaiser member? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any of your dependents waived Kaiser coverage in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Effective Date Requested (must be 1st of month following employer waiting period)				Occupation		

NOTE: Any dependent child age 19 or over will not be added until Section 8 of this form is completed and approved.

SECTION 4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION							
Name	Last	First	M. I.	Birthdate MM/DD/YYYY	Sex		Existing Patient Yes No
<i>Employee</i>				<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> Self			
<i>Spouse</i>			<i>Date of Marriage</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> Spouse			
<i>First dependent*</i>				<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> <input type="checkbox"/>			
<i>Second dependent*</i>				<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> <input type="checkbox"/>			
<i>Third dependent*</i>				<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> <input type="checkbox"/>			
<i>Fourth dependent*</i>				<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
SS #	—	—		<i>Relationship</i> <input type="checkbox"/>			

SECTION 5 HEALTH CARE COORDINATION

To assist our Medical Management Team in coordinating your care, please answer the following questions:

1. Is anyone listed in Section 4 above currently receiving ongoing medical care for a serious illness or condition? Yes No
If yes, who? _____

2. Does anyone listed in Section 4 above require medical care for a chronic illness or condition? Yes No If yes, who? _____

SECTION 6 DISABILITY INFORMATION

1. Do you believe that you or any family member for whom you are applying for coverage would be considered totally disabled according to the definitions of disability given on the back of this application?
 Yes No If yes, who?

Disabling Condition(s) _____ Date Disability Commenced _____

SECTION 7 OTHER HEALTH INSURANCE

1. Is anyone listed in Section 4 on previous page eligible for Medicare? Yes No If yes, who? _____

2. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months?
 Yes No If yes, complete the section below. Please list all current or prior medical coverage. **Failure to provide complete information may result in significant delay of claims processing.** (Attach additional sheets if necessary)

Covered Person's Name	Policy Holder Name(s)	Insurance Company Name(s)	Type of Coverage	Policy No.	Effective Date	Termination Date
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			

IMPORTANT

SECTION 8 FULL TIME STUDENT VERIFICATION

Any dependent age 19 or over cannot be added unless they are a full-time student. Requirements for dependent student coverage: Full-time student in an accredited institute, dependent upon employee for support, unmarried, under 25 years of age

Dependent's Name	Birthdate	School Year
School Name	Student I.D. #	Current # of Units
School Address	City	State Zip
Dependent's Name	Birthdate	School Year
School Name	Student I.D. #	Current # of Units
School Address	City	State Zip
Dependent's Name	Birthdate	School Year
School Name	Student I.D. #	Current # of Units
School Address	City	State Zip

Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and that you have read the Plan information including the information listed on pages 2, 3, & 4 of this form and understand all agreements, including your agreement to submit disputes to binding arbitration.

Employee Signature _____ Date _____

SECTION 9 ACCEPTANCE OF COVERAGE

Explanation of Authorization to Obtain or Release Medical Information: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested. **Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of Kaiser or Printing Industries Benefit Trust or its agents, designees or representatives, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize Kaiser, Printing Industries Benefit Trust or its agents, designees or representatives, to disclose to a hospital

or health care service plan, self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Kaiser or Printing Industries Benefit Trust or its agents, designees or representatives to process claims and benefits.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and Kaiser, Printing Industries Benefit Trust or its agents, designees or representatives or any Participating Medical Group/ Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

SECTION 10 DISABLING CONDITIONS

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, you may be entitled to an extension of health benefits according to California Insurance Code § 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the Maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

Total disability, as it relates to the law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age.

Application for enrollment under the Kaiser Plan will not be considered unless the Disability Information section is completed. Please answer the questions as completely as possible to avoid delay in the processing of your application.

SECTION 11 PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

I understand that the Participating Providers, if any, do not necessarily include all types, of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize that payment be made under Part B of Medicare to participating provider for medical and other services furnished me for which it pays or has paid, if applicable.

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform Printing Industries Benefit Trust and will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the plan, I will immediately reimburse the plan to the extent of services provided, to the extent permitted by state law.

SECTION 12 SERVICE AREAS

The service area is that portion of Kern, Los Angeles, Orange, Riverside, San Bernadino, San Diego, and Ventura Counties within the following zip codes:

90000-899	92049	92260-64*	92357-59	92599	93224-26	93518-19
(except 90704)	92051-58	92268*	92369	92600-899	93238	93531-32
91000-899	92064-65	92270*	92371-78	93000-09*	93240-41	93534-36
91901-03	92067-69	92274-78*	92382	93010-12	93243	93539
91908-17	92071-72	92282*	92385-86	93015-16	93250-52	93543-44
91921	92074-75	92284-86*	92391-94	93020-21	93261	93550-53
91931-33	92079	92292*	92397	93022*	93263	93560-61
91935	92082-85	92305	92399	93030-35*	93268	93563
91941-47	92090-93	92307-08	92400-99	93040	93276	93581-82
91950-51	92096	92313-18	92500-32	93041-44*	93280	93584
91962-63	92100-99	92320-22	92543-46	93060-61*	93285	93586
91976-80	92201-03*	92324-26	92548	93062-66	93287	93590-91
91990-91	92210-11*	92329	92551-57	93093	93301-09	93599
92007-09	92220	92333-37	92562-64	93099	93311-13	
92014	92223	92339-41	92567	93203	93380-90	
92018-27	92230*	92345-46	92570-72	93205-06	93399	
92029-30	92234-36*	92350	92581-87	93215-17	93501-02	
92033	92240-41*	92352	92595-96	93220	93504-05	
92037-40	92252-56*	92354		93222	93510	
* 92046	92258*					

* Subscribers residing in Coachella Valley (greater Palm Springs area) and western Ventura County are required to select an Affiliated Primary Care Physician for themselves and each covered dependent. Members will be contacted after enrollment regarding Affiliated Primary Care Physician selection.

Kaiser Permanente does not service all areas. For the complete list of zip codes, visit the Kaiser website at: www.kaiserpermanente.org.

SECTION 13	NORTHERN CALIFORNIA SERVICE AREAS
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The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within the following ZIP codes:

93230	94002-03	94497	95013-15	95323	95630
93232	94005	94501-03	95020*	95326	95632-35
93242	94010-12	94506-31	95026	95328-30	95638-41
93601-02	94013-31	94533-53	95030-33	95336-37	95645
93604	94035	94555-66	95035-38	95350-58	95648
93606-07	94037-45	94567*	95042	95360-61	95650-52
93609	94059-67	94568-81	95044	95363	95655
93611-14	94070-71	94583	95046	95366-68	95658-64
93616	94074	94585-92	95050-56	95376-78	95667-74
93618	94080	94595-99	95070-71	95380-82	95676-78
93623-27	94083	94601-15	95101-03	95385-87	95680-83
93630-31	94085-90	94617-27	95106	95391	95686-88
93637-39	94096	94643	95108-42	95397	95690-98
93643-46	94098-99	94649	95148	95401-09	95703
93648-54	94101-12	94659-62	95150-61	95416	95722
93656-57	94114-47	94666	95164	95419	95736
93660	94150-72	94701-10	95170-73	95421	95741-43
93662	94175	94712	95190-94	95425	95746-47
93666-69	94177	94720	95196	95430-31	95758-59
93673	94188	94801-08	95201-13	95433	95762-63
93675	94203-09	94820	95215	95436	95765
93701-12	94211	94850	95219-20	95439	95776
93714-18	94229-30	94875	95227	95441-42	95798-99
93720-22	94232	94901	95230-31	95444	95812-38
93724-29	94234-37	94903-04	95234	95446	95840-43
93740-41	94239-40	94912-15	95236-37	95448	95851-53
93744-45	94243-50	94920	95240-42	95450	95857
93747	94252-54	94922-31	95253	95452	95860
93750	94256-59	94933	95258	95462	95864-67
93755	94261-63	94937-42	95267	95465	95873
93760-62	94267-69	94945-57	95269	95471-73	95887
93764-65	94271	94960	95290	95476	95894
93771-80	94273-74	94963-66	95296-98	95486-87	95899
93784	94277-80	94970-79	95304	95492	95903
93786	94282-91	94998-99	95307	95602-05	95961
93790-94	94293-99	95002	95313	95607-21	
93844	94301-10	95008-09	95316	95623-26	
93888	94401-09	95011	95319-20	95628	

*Exception: The communities of Bells Station and Knoxville are not in our service area.