



All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Addendum to Employee Enrollment/Change

This form must accompany the Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Employee Enrollment/Change Form.

This section to be completed by the employer.

Company name* _____ Effective date of coverage* ____ / ____ / ____
Group no.* _____ Medical subgroup no. _____ Dental subgroup no. _____

A Employee information (Employee completes sections A, B, and C.)

Name (last, first, MI)* _____ Former/maiden name (if any) _____
Gender* M F Date of birth* ____ / ____ / ____ Social Security no. _____

B Dependent information

Child name (last, first, MI) _____ Full-time student Disabled Yes No
Gender* M F Date of birth* ____ / ____ / ____ Social Security no. _____ Medical Dental
Other health insurance Yes No Insurance co. _____ Policy no. _____
Health record no. (if any) _____ Medicare eligible Yes No Medicare ID no. _____

Child name (last, first, MI) _____ Full-time student Disabled Yes No
Gender* M F Date of birth* ____ / ____ / ____ Social Security no. _____ Medical Dental
Other health insurance Yes No Insurance co. _____ Policy no. _____
Health record no. (if any) _____ Medicare eligible Yes No Medicare ID no. _____

Child name (last, first, MI) _____ Full-time student Disabled Yes No
Gender* M F Date of birth* ____ / ____ / ____ Social Security no. _____ Medical Dental
Other health insurance Yes No Insurance co. _____ Policy no. _____
Health record no. (if any) _____ Medicare eligible Yes No Medicare ID no. _____

Child name (last, first, MI) _____ Full-time student Disabled Yes No
Gender* M F Date of birth* ____ / ____ / ____ Social Security no. _____ Medical Dental
Other health insurance Yes No Insurance co. _____ Policy no. _____
Health record no. (if any) _____ Medicare eligible Yes No Medicare ID no. _____

Check here if another Addendum to Employee Enrollment/Change Form is attached.

C Important

It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee signature* _____ Date ____ / ____ / ____

*Required