

Please print or type in black ink only. Please see instructions on reverse before completing this form  
Fields with \* are mandatory for enrollment.

<b>A. TO BE COMPLETED BY INSTITUTION</b>							
Graduate Theological Union Students 2400 Ridge Road, Berkeley CA 94709		600614 - _____					
Institutions ID: _____		Effective Date: _____					
*ENROLLMENT (check only one - see Enrollment Reason Table on reverse side for options)							
<input type="checkbox"/> New Student Enrollment		<input type="checkbox"/> Open Enrollment					
<input type="checkbox"/> Part Time to Full Time - Date: _____		<input type="checkbox"/> Other: _____ Event Date: _____					
<input type="checkbox"/> New Purchaser							
<b>B. STUDENT/SUBSCRIBER INFORMATION</b>							
Are you now or have you ever been a Kaiser Permanente Member? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If so, what is/was your Medical Record Number? _____							
Have you ever received care from Kaiser Permanente within the State of California? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Under what name: _____ Maiden/Other							
*Social Security Number _____/_____/_____	*Last Name _____	*First Name _____	MI _____				
*Date of Birth ____/____/____	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single					
Preferred Language Spoken _____	Preferred Language Written _____	E-mail Address (optional) _____					
*Street Address ( ) _____	*City ( ) _____	*State _____	*ZIP Code _____	Employment Status: <input type="checkbox"/> Working <input type="checkbox"/> Retired			
Day Phone <input type="checkbox"/> Home <input type="checkbox"/> Work	Evening Phone <input type="checkbox"/> Home <input type="checkbox"/> Work	Student ID _____					
<b>C. LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet if needed)</b>							
*Last Name	*First Name	MI	*Role	*Social Security Number	*Date of Birth MM/DD/YY	*Gender	Medical Record Number if Known
<b>Spouse</b> Maiden/Other: _____			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent</b> Relationship: _____			<input type="checkbox"/> Child <input type="checkbox"/> Student	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent</b> Relationship: _____			<input type="checkbox"/> Child <input type="checkbox"/> Student	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent</b> Relationship: _____			<input type="checkbox"/> Child <input type="checkbox"/> Student	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent</b> Relationship: _____			<input type="checkbox"/> Child <input type="checkbox"/> Student	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent</b> Relationship: _____			<input type="checkbox"/> Child <input type="checkbox"/> Student	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Dependent(s') Address (if different from subscriber's):</b> <input type="checkbox"/> Check here if all dependents are at the address below.							
Name(s)	Address			City	State	ZIP Code	

I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the *Evidence of Coverage*.

**X**  
\* Employee/Subscriber Signature

**X**  
\*Date

## Enrollment Application Instructions

### General Instructions:

1. Please print firmly and legibly in black ink.
2. To be enrolled, you must reside within one of the ZIP codes listed on the enclosed sheet.
3. The institution must complete Section A
4. The institution is responsible for confirming all Information prior to submission
5. The student/subscriber must complete Sections B and C. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including Section A), the subscriber should retain the last copy for their records to use as a temporary ID card, after the effective date.
8. All enrollments will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

### Instructions for completing Sections A through C:

**Section A:** The institution must complete all fields to ensure we have correct account and enrollment reason information. Always indicate the appropriate enrollment reason. For “other” enrollment requests, write in the reason from the table below. Be sure to include the event date, where requested.

**Section B:** The subscriber should complete all fields in this section to ensure we have your current information and can find any prior membership records.

**Section C:** The subscriber should complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any prior last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an “overage dependent” attending school.

Please contact your institution regarding their rules for overage dependent students. A completed Student Certification Form may be required.

### Enrollment Reason Table

Enrollment Reason	Event Date
Part-Time to Full-Time Status	Effective Date of Full-Time Status
Loss of Coverage	Date Coverage Was Lost
Moved into Service Area	Move Date
Re-enrollment	Date of Re-enrollment
Return from leave of absence	Return Date
Return from Military Duty	Return Date