

Please print or type in black or dark blue ink only. Please see instructions on reverse *before* completing this form.
 Retain last copy for your records and use as a temporary ID.

A. TO BE COMPLETED BY EMPLOYER

EMPLOYEE LEASING, INC.	113653	-	0003	
Company Name or Trust Fund Name	Purchaser Number		Enrollment Unit Number (EU)	
5256 S. Mission Rd., #808, Bonsall CA 92003				
Employer ID	Company Address or Trust Fund Address			
LEIZEL DEGUZMAN				
Purchaser Contact	(760) 639-6013		(760-) 639-6074	
	Phone Number		Fax Number	

ENROLLMENT (check only one)

<input type="checkbox"/> New Hire Enrollment—Date of Hire: _____	<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	See Enrollment Reason Table on above page for options.

B. EMPLOYEE/SUBSCRIBER INFORMATION

Are you now or have you ever been a Kaiser Permanente member? Yes No
 If so, what is/was your Medical Record Number? _____
 Have you ever received care from Kaiser Permanente within the state of California? Yes No
 Under what name: _____
Maiden/Other

Social Security Number	Last Name	First Name	MI
_____/_____/_____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Date of Birth			
Preferred Language Spoken	Preferred Language Written	E-mail Address (optional)	
Street Address	City	State	ZIP Code
(_____) _____	(_____) _____	Employment Status:	
<input type="checkbox"/> Day Phone <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Evening Phone <input type="checkbox"/> Home <input type="checkbox"/> Work	Employee ID	<input type="checkbox"/> Working <input type="checkbox"/> Retired

C. LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed)

Last Name	First Name	MI	Role	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Known
Spouse			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<i>Maiden/Other:</i>							
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<i>Relationship:</i>							
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<i>Relationship:</i>							
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<i>Relationship:</i>							
Dependent			<input type="checkbox"/> Child <input type="checkbox"/> Student	— —	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<i>Relationship:</i>							

Dependent(s)' Address (if different from subscriber's): 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 and claims subject to a Medicare appeals procedure, 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, respectively 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*.

Employee/Subscriber Signature	Date
TOP COPY—To Kaiser Permanente (CSC) MIDDLE COPY—To be retained by purchaser BOTTOM COPY—To be retained by subscriber and used as temporary ID	