Bay East Association of Realtors®

KAISER®

IMPORTANT INSTRUCTIONS:

Please complete all information requested and write your Bay East Association of Realtors® member number at the top of the application.

Please type or write in ink.

Include payment for two month's premium payable to "ARBA".

Send the original application and check to:

AUSTIN & AUSTIN INSURANCE SERVICES, INC.
5890 STONERIDGE DRIVE #209
PLEASANTON, CA 94588

Please call our office to confirm receipt and with any questions,

1-800-987-1475

COVERAGE DOES NOT BECOME EFFECTIVE UNDER ANY CIRCUMSTANCES UNTIL AND UNLESS THE APPLICATION HAS BEEN APPROVED BY KAISER PERMANENTE®

AUSTIN & AUSTIN
INSURANCE SERVICES, INCORPORATED

CA Lic #0C10853

☐ $15 Copay Plan
☐ $20 Copay Plan
☐ $30 Copay Plan
☐ $50 Copay Plan

☐ $30 Copay/$1000 Deductible Plan
☐ $30 Copay/$1500 Deductible Plan
☐ $0 Copay/$2000 Deductible HSA Plan
☐ $0 Copay/$2700 Deductible HSA Plan

☐ $40 Copay/$2000 Deductible Plan
☐ $30 Copay/$3000 Deductible HSA Plan

Realtor Association Member Number _____

KAISER PERMANENTE® Enrollment Application

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

A. TO BE COMPLETED BY EMPLOYER

*Company or Trust Fund Name | *Purchaser Number | Enrollment Unit Number (EU)

Company or Trust Fund Address | ( ) Phone Number | ( ) Fax Number

Purchaser Contact | Employer ID | *Effective Date of Coverage

***ENROLLMENT (check only one—see Enrollment Reason Table on reverse side for options)**

❑ New Hire Enrollment—Date of Hire: _____ ☒ Open Enrollment
❑ Part Time to Full Time—Date: _____ ❑ Other: _____ Event Date: _____
❑ New Purchaser

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

Height _____
Weight _____

_ _ _ – _ _ – _ _ _ _ | *Last Name | *First Name | MI

*Social Security Number

*Gender: ❑ M ❑ F

Marital Status: ❑ Married ❑ Single

__/__/__ *Date of Birth

Preferred Language Spoken | Preferred Language Written | E-mail Address (optional)

*Street Address | *City | *State | *ZIP Code

( ) Day Phone ❑ Home ❑ Work | ( ) Evening Phone ❑ Home ❑ Work | Employee ID

Employment Status: ❑ Working ❑ 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	Height	Weight
Spouse *Maiden/Other:*			❑ Spouse ❑ Domestic Partner	– –	/ /	❑ M ❑ F			
Dependent *Relationship:*			❑ Child ❑ Student	– –	/ /	❑ M ❑ F			
Dependent *Relationship:*			❑ Child ❑ Student	– –	/ /	❑ M ❑ F			
Dependent *Relationship:*			❑ Child ❑ Student	– –	/ /	❑ M ❑ F			
Dependent *Relationship:*			❑ Child ❑ Student	– –	/ /	❑ M ❑ F			

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

Kaiser Foundation Health Plan Arbitration Agreement:
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 | *Date

DISCLOSURE

Attention: If you are enrolling in a Plan through the Association, this signed letter of understanding must accompany your application.

The Deductibles and Out of Pocket Maximums of these plans are based on a Calendar Year.

Please remember this is a calendar year Deductible and Out of Pocket Maximum plan, **not** plan year. Any expenses you accrue will apply to the Deductible and Out of Pocket Maximum for the Calendar Year, which starts January 1 and ends December 31, EVEN if you enroll in a month other than January.

Example: If you enroll in the plan in October and accrue expenses for October, November and December, whether you have met the deductible or not, a new Deductible and Out of Pocket maximum will begin in January of the following year.

*** **Deductibles and Out of Pocket Maximums are always Calendar Year*****

I understand the above information regarding Deductibles and Out of Pocket maximums.

_____ _____

Association Member Spouse

_____Date _____Date