KAISER PERMANENTE®

~~Return completed form to:~~
~~P.O. Box 34750, Seattle, WA 98124-1750~~

2021 Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Effective date January 1, 2021

~~Termination date~~ _____

Group name Mitutoyo Research & Development America, Inc.

~~Group number~~ _____

Selected health plan Choose one

~~Pay location (if applicable)~~ _____

~~Original date of hire ____/____/____~~

~~Date of rehire ____/____/____~~

~~Date transferred from part time (p/t) to full time (f/t) ____/____/____~~

~~Hours worked per week _____~~

~~If retired, date of retirement ____/____/____~~

Choose one:

- [x] Open enrollment
- [ ] New employee
- [ ] Address/name change
- [ ] Add dependent(s)
- [ ] Remove coverage
  - ___ Employee
  - ___ Dependent(s)
- [ ] Qualifying event _____

~~Date processed ____/____/____ by _____~~

~~[ ] Transfer to COBRA~~
~~Start date ___/___/___~~
~~[ ] 18 months~~
~~[ ] 36 months~~

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Work phone (_____) _____
(Last name) (First name) (M.I.)

Resident address _____ Home phone (_____) _____
(Street) (City) (State) (ZIP)

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse (if applicable) _____

*By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

~~For health plan internal use only~~	Check one Add	Check one Remove	Please print Last name First name M.I.	Social Security number	Male/ Female	Birthdate (MM/DD/YY)	Relationship to employee
	[ ]	[ ]	Self				
	[ ]	[ ]	Spouse/domestic partner/dependent ~~(circle one)~~				
	[ ]	[ ]	Dependent				
	[ ]	[ ]	Dependent				
	[ ]	[ ]	Dependent				

_____

(Signature of employee) Please type your name in lieu of signature (Date signed)

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. In Washington state, a registered domestic partner is treated the same as a spouse. If children of the primary insured are covered, children of a domestic partner are eligible for coverage on the same basis. All plans offered and underwritten by Kaiser Foundation Health Plan of Washington, registered in Washington state, or Kaiser Foundation Health Plan of Washington Options, Inc., registered in Washington and Idaho. 601 Union St., Suite 3100, Seattle, WA 98101.