Federal and Postal Employee Dental Plan Enrollment Form

Please print in black or blue ink only.

KAISER PERMANENTE®

A Employee information

Name *(last, first, MI)** _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

Home address* _____ Apt. _____

City _____ State _____ ZIP _____ Personal email _____

Home phone* _____ Work phone _____

Employment status ☐ Active ☐ Retired AFGE local number (if applicable) _____

B Dependent information *(For additional dependents, please use space provided on back of this form.)*

Dependent children, if covered, are covered through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan.

☐ Spouse ☐ Domestic partner† Name *(last, first, MI)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

Child name *(last, first, MI)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

Child name *(last, first, MI)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

Child name *(last, first, MI)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

Child name *(last, first, MI)* _____

Gender* ☐ M ☐ F Date of birth* ___ / ___ / ___ Social Security no.* _____

C Important — *Your application cannot be processed without your signature.*

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. I acknowledge by my signature that the information I have supplied on this form is true and correct.

Employee signature* _____ Date ___ / ___ / ___

**Required.*

†*A person legally recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group. Washington state registered domestic partners are treated the same as a spouse. If children of the primary insured are covered, children of domestic partners are covered on the same basis.*

Mail this completed form to:
Kaiser Permanente Federal Dental Plans
c/o Camco Benefit Services
P.O. Box 5667, Lacey, WA 98509

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

B Dependent information

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

Child name *(last, first, MI)*

Gender* ☐ M ☐ F Date of birth* ____ / ____ / ____ Social Security no.* ____________________

☐ For additional dependents, check this box and fill out another copy of this form.

C Important

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. I acknowledge by my signature that the information I have supplied on this form is true and correct.

Employee signature* ______________________________ Date ____ / ____ / ____

**Required.*

These benefits are neither offered nor guaranteed under contract with the FEHBP but are made available to all FEHBP-eligible enrollees and their covered family members.