How to fill out forms:

APPLICATION

1. Please print legibly in black or blue ink.
2. To be enrolled, you must live or work within the Northwest service area at least 50 percent of the time.
3. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Read section C then sign and date the form(s).
4. Once your application form is complete, make a copy for your records.

ACH AUTHORIZATION FOR PAYMENT*

1. Please print legibly in black or blue ink.
2. If you are an AFGE member, be sure to supply your Union Local number to avoid being charged an association fee.
3. Make sure your Routing and Account numbers are correct and complete. Incorrect submissions will result in a delay of coverage.
4. Sign and date the ACH form.
5. All Monthly ACH members will be debited on the 10th of every month beginning JAN 10 of each policy year.
6. A yearly administrative fee of $5.00 will be debited on the final Friday

Mail your completed application and ACH authorization to:

CAMCO BENEFIT SERVICES
PO Box 5667
Lacey, WA 98509

-OR-

Scan and email your completed application and ACH authorization to:
info@camcobenefits.com

-OR-

FAX your completed application and ACH authorization to: 1-360-438-6256

***If you choose not to make payments through our ACH debit plan, please call our office to discuss alternate payment methods. We cannot take credit card payments at this time.

If you have questions or need help completing these forms, please call 1-844-206-5032

APPLICATION MUST BE RECEIVED BY CAMCO BENEFIT SERVICES NO LATER THAN DECEMBER 15 TO ENSURE ENROLLMENT EFFECTIVE JAN 1

Federal Employee Dental Plans Enrollment Form

Please print in black or blue ink only.

KAISER PERMANENTE®

A Employee information

Select plan: ☐ Dental Preferred ☐ Dental Select

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.)*

☐ 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*

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.

KAISER PERMANENTE®

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

Camco Benefit Services

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

For Kaiser Permanente® Federal Employee Dental Plan Premiums

(Automated Clearing House Debits, ACH)

NAME (PLEASE PRINT) _____ PHONE _____

EMAIL _____ AFGE UNION LOCAL # (IF APPLICABLE) _____

I (we) hereby authorize **Camco** to initiate debits for dental plan premiums by the 10th of each month to my (our) account and financial institution named below

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

☐ CHECKING or ☐ SAVINGS (account type)

BANK NAME _____

TRANSIT/ROUTING/ABA NUMBER _____

ACCOUNT NUMBER _____

This authorization is to remain in full force and in effect until CAMCO has received WRITTEN request for TERMINATION of coverage in such time and in such manner to afford CAMCO and DEPOSITORY a reasonable opportunity to act.

SIGNED _____ DATE _____

This dental agreement is active from your initial effective date through December 31st of the same calendar year, subject to timely payment of premium each month. No bills or invoices for dental premiums will be sent. Premiums are due by the 10th of each month for that month's coverage. Failure to pay premium may result in termination of your dental coverage. If your coverage is terminated for nonpayment of premium, you will not be eligible to re-enroll in a Kaiser Permanente Federal Employee Dental Plan until the next open enrollment period. THERE WILL BE A **$35.00** SERVICE FEE FOR ANY RETURNED ITEMS OR INSUFFICIENT FUNDS.

camco benefit services

Send completed form to:

Kaiser Permanente Federal Dental Plans
c/o Camco Benefit Services
P.O. Box 5667
Lacey, WA 98509

Toll-Free **844-206-5032** FAX **360-438-6256**

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