How to fill out forms:

APPLICATION AND ADDENDUM

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. If needed, use the addendum to add more dependents. Read section C then sign and date the form(s).
4. Once your application form is complete, make a copy for your records. You will soon get a membership ID card mailed to your home address.

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. Incorrect submissions will result in a delay of coverage.
4. Sign and date the ACH form.
5. All ACH members will be debited on the 10th of every month beginning JAN 10, 2017.

Mail your completed application and ACH authorization to:

KP Federal Dental Plan,
C/O Camco Benefit Services,
PO Box 5667
Lacey, WA 98503

-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, please include a personal check or money order for one-month's premium amount and mail with your application to the address above. Please make checks payable to CAMCO BENEFIT SERVICES. Be sure your first premium includes the $5.00 administrative fee if applicable.
Please complete the ACH form attached, but do not include your banking information. Instead, please write in the spaces provided that you wish to become a MONTHLY CHECK PAYOR.

Sign and date the Authorization form and submit it with your application and your check.

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

Federal Dental Employee Enrollment Form

Please print in black or blue ink only.

KAISER PERMANENTE®

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

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 Union 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.*

I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

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 98503

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.

Federal Dental
Employee Enrollment Form

Please print in black or blue ink only.

KAISER PERMANENTE®

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 may include imprisonment, fines, and denial of insurance benefits.

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®

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 debit entries to my (our) account and financial institution named below in the amount of the plan and premium elections indicated on my enrollment form.

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)

Debits are on the 10th of the Month

BANK NAME _____

TRANSIT/ROUTING/ABA NUMBER _____

ACCOUNT NUMBER _____

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

SIGNED_____ DATE ____/____/_____

This dental agreement is active for a period of 12 months from your initial effective date.

A **$35.00** SERVICE FEE WILL BE CHARGED FOR RETURNED ITEMS OR INSUFFICIENT FUNDS. AN EARLY TERMINATION WILL RESULT IN A FEE OF $100.

camco benefit services

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