

Kaiser Permanente Dental Plan Enrollment Form for Postal Service Members



Please print in black or blue ink only.

A Enrollee 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 AFGC 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.

Enrollee 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 Postal Dental Plans
c/o Camco Benefit Services
P.O. Box 5667, Lacey, WA 98509

FWENRPSHB193000126

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.
1727933897_OE_09-25

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

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Enrollee signature* _____ Date ____ / ____ / ____

**Required.*

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