



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

2-in-1 Employee Benefit Designation Form

Group name: _____ Group number: _____

Policy effective date: _____ Check if Enrollment Application/Change of Information Form is attached.*

*Please note: If an employee is enrolling for the first time or if an employee wishes to add dependents, he or she must sign this form and fill out a separate Enrollment Application/Change of Information Form. If an employee wishes to cancel dependents, he or she must fill out a separate Member Cancellation of Coverage Form.

Benefit plan _____

Employee name and signature

1. _____
PRINTED NAME

SIGNATURE
2. _____
PRINTED NAME

SIGNATURE
3. _____
PRINTED NAME

SIGNATURE
4. _____
PRINTED NAME

SIGNATURE
5. _____
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SIGNATURE
8. _____
PRINTED NAME

SIGNATURE
9. _____
PRINTED NAME

SIGNATURE
10. _____
PRINTED NAME

SIGNATURE

Benefit plan _____

Employee name and signature

1. _____
PRINTED NAME

SIGNATURE
2. _____
PRINTED NAME

SIGNATURE
3. _____
PRINTED NAME

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