

15551 Summit Avenue
Fontana, California 92336
Phone: (909) 357-5950
Fax: (909) 357-5961



Number: _____
(Office Use Only)

Kaiser Permanente Individual Enrollment

Name: _____ Date of Birth: _____ Date: _____

Email Address: _____

Company Name: _____

Company Phone Number: (____) _____ - _____

Company Address: _____

Offered Plans

Please check the box next to the plan of your choice

Plan	<input type="checkbox"/> PowerPlan 1	<input type="checkbox"/> PowerPlan 2	<input type="checkbox"/> PowerPlan 3
Co-Payment	\$5.00	\$10.00	\$15.00
Monthly Payment	\$250.00	\$150.00	\$100.00

Sales Receipt

Please circle method of payment: Check or electronic transfer via virtubank

Choose payment amount:

Powerplan 1-\$250.00 **Powerplan 2**-\$150.00 \$ _____

Powerplan 3-\$100.00

Check Number or Virtubank transfer number _____

Total payment amount received \$ _____

Insurance will be effective the 1st of the following month.

***A payment schedule will be mailed to you within 10 days.**

Signature _____ Date: _____