

## Opt In Form

**Instructions:** If you wish to have your arbitration administered by the Independent Administrator and governed by *Rules for Kaiser Permanente Member Arbitrations Administered By the Office of the Independent Administrator*, you can do so by filling out this form and returning it to the address set out below. If the Claimant is represented by counsel, counsel must sign the form. If the Claimant is not represented by counsel, the Claimant must sign the form. If there is more than one Claimant, each Claimant must sign the form.

Office of the Independent Administrator for the  
Kaiser Foundation Health Plan, Inc.  
3580 Wilshire Boulevard, Suite 2020  
Los Angeles, CA 90010  
Facsimile: 213/637-8658

Name(s) of Claimant(s) \_\_\_\_\_  
\_\_\_\_\_

I/We, the Claimant(s) in the arbitration listed above, wish to be part of the arbitration system that is administered by the Independent Administrator and governed by the *Rules for Kaiser Permanente Member Arbitrations Administered By the Office of the Independent Administrator*. I/we agree to follow and be bound by these Arbitration Rules. I/we understand that California statutory law may require that this arbitration be completed in less time than that specified by the Arbitration Rules. I understand that under the *Rules*, my filing fee may be non-refundable. See Rule12.

I/We make this decision voluntarily and after the opportunity to discuss the decision with counsel.

\_\_\_\_\_  
Signature of Claimant or Claimant's Counsel

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date