Group & FEHB Enrollment Form

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, MD 20852
kp.org/medicare

KAISER PERMANENTE®

IMPORTANT INFORMATION – Read all pages of the enrollment form before signing

Completing and returning this form is your first step to becoming a Kaiser Permanente Medicare health plan member sponsored by your former employer. If you and your spouse are both applying, you will each need to complete a separate form. If you have any questions concerning benefits and services that are provided by or excluded under this agreement, or for help completing this form, call Member Services, seven days a week, between 8 a.m. and 8 p.m., toll free at **1-888-777-5536**, or **TTY 711** before signing this form.

ELIGIBILITY

You may not enroll in a Kaiser Permanente Medicare health plan if you currently have End-Stage Renal Disease (ESRD) unless:

a. You are a member of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in good standing and were diagnosed with ESRD during your current membership,

b. You had a successful kidney transplant 36 or more months ago, or

c. You do not need regular dialysis anymore.

Please attach a note or records from your doctor if items b or c above applies to you.

FOR KAISER PERMANENTE MEDICARE PLUS (COST) MEMBERS: We need verification that you are enrolled in Medicare Part B and that you live within our Kaiser Permanente Medicare health plan service area for us to enroll you.

FOR KAISER PERMANENTE MEDICARE ADVANTAGE (HMO) MEMBERS: We need verification that you are enrolled in Medicare Part A and Medicare B and that you live within our Kaiser Permanente Medicare health plan service area for us to enroll you.

HOW TO FILL OUT THIS FORM

1. Remove the perforated tab at the top of the page and separate all pages BEFORE filling out the form. Fill out the form completely and **keep the pink copy** for your records. **Mail the white and yellow copies** to Kaiser Permanente in the enclosed postage-paid envelope; OR if so instructed, return the application to your group's benefits administrator.
2. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
3. Sign the form on page 6 and date it. **Make sure you've read all the pages before you sign.**
4. Keep the pink copy for your records.
5. Mail the completed form to Kaiser Permanente in the enclosed postage-paid envelope: OR if so instructed return the application to your group's benefits administrator.

- **Do not drop off your application at a Kaiser Permanente Medical Center** as this may delay your enrollment.

When we receive your application, we will verify your eligibility. Upon acceptance, we will send you a letter that tells you the date your coverage becomes effective. Later, we will send your Kaiser Permanente Medicare health plan identification card. You should not disenroll from any Medicare supplemental plan or Medigap or Medicare Select Plan until you receive written notification from us confirming that Medicare has approved your enrollment.

Name

Kaiser Permanente Medical Record Number

A. To Enroll in a Kaiser Permanente Medicare health plan, Please Provide the Following Information:

Please indicate your requested enrollment effective date (mm/dd/yyyy) / /

LAST Name: ☐ Mr. ☐ Mrs. ☐ Ms.

FIRST Name: Middle Initial: Gender: ☐ M ☐ F

Phone Number: - -

Birth Date: (mm/dd/yyyy) / /

Permanent Residence Street Address:

City:

County: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City: State: ZIP Code:

E-mail Address:

Name of Employer providing retiree health benefits:

Under Medicare regulations, a Medicare beneficiary can be enrolled in only one Medicare health plan or Medicare Prescription Drug Plan at a time. If you currently have Kaiser Permanente coverage through more than one employer or trust fund, you must choose only one of these coverages for your Medicare health plan. Your other employer may allow you to maintain your non-Medicare coverage as well. We suggest that you contact the benefit administrators at each of your employers or trust funds to understand the employer or trust fund coverage that you are entitled to before you make a decision about which coverage to choose for your Medicare health plan.

Warning MD residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Name

Warning VA residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may have violated the state law.

B. Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part B to join a Medicare Cost plan. You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To
Hospital (Part A) Effective Date: / /

Medical (Part B) / /

C. Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? ☐ Yes ☐ No

   Will you have health coverage through your or your spouse's current or former employer in addition to this Medicare plan? ☐ Yes ☐ No

   If "yes," please provide the following information or attach a copy of both sides of your health insurance card:

   Employer Name

   Employer Address

   Policy Holder Name

   Policy Number

   Name of other coverage

   Effective Date (mm/dd/yyyy) / /

Name

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If "yes," please provide your Medicaid number

4. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse's employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

   Do you or will you have other prescription drug coverage in addition to Kaiser Permanente? ☐ Yes ☐ No

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage or provide a copy of your prescription drug card:

Name of other coverage	ID # for this coverage	Group # for this coverage

5. Have you ever been or are you now a Kaiser Permanente member?

   ☐ Yes, current member ☐ Yes, previous member ☐ No

   If yes, please list medical record number

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "yes," please provide the following information:

   Name of institution:

   Address of institution (number and street):

   Phone number: - -

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Braille ☐ Spanish

Please contact Kaiser Permanente at **1-888-777-5536** if you need information in accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

Name

D. Please Read the following and Sign on Page 7:

By completing this enrollment application, I agree to the following:

For Medicare Plus members: Kaiser Permanente Medicare Plus is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to Kaiser Permanente or by calling **1-800-MEDICARE, (1-800-633-4227)** anytime, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

For Medicare Advantage members: Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

For Medicare Plus and Medicare Advantage FEHB members only: I understand if I disenroll from Kaiser Permanente Medicare Plus or Medicare Advantage for Federal Employees, it means ending my membership in Kaiser Permanente Medicare Plus or Medicare Advantage but continuing to be a member of Kaiser Permanente through the Federal Employees Health Benefits Program (FEHBP). I will continue to receive care from Kaiser Permanente plan providers (although my copays and coinsurance will change). If I wish to discontinue my membership in Kaiser Permanente FEHBP, I must contact my employing office or retirement office to find out how to change to a different FEHBP health plan.

Kaiser Permanente Medicare health plans serve a specific service area. If I move out of the area that my Kaiser Permanente Medicare health plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that, if I am already a member of a non-Medicare Kaiser Permanente Individual plan, this application does not automatically disenroll me from the plan in which I am enrolled. I will need to place my intent to disenroll from my current Kaiser Permanente plan in writing.

Once I am a member of a Kaiser Permanente Medicare health plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Kaiser Permanente when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

Name

FOR RESIDENTS OF VIRGINIA, AND FREDERICK, CARROLL AND CALVERT COUNTIES IN MD:
I understand that beginning on the date Kaiser Permanente Medicare Plus coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently-needed services, all of my health care must be provided or arranged by Kaiser Permanente Medicare Plus. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

FOR RESIDENTS OF ANNE ARUNDEL, BALTIMORE, CHARLES, HOWARD, HARFORD, MONTGOMERY, PRINCE GEORGE'S COUNTIES IN MD, THE CITY OF BALTIMORE, AND THE DISTRICT OF COLUMBIA: I understand that beginning on the date Kaiser Permanente Medicare Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente Medicare health plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that any misrepresentation of information may void my membership and benefits retroactively to the date Kaiser Permanente benefits began and Kaiser Permanente has the right to pursue payment for services rendered. I will be entitled to a refund of paid premiums from the date of coverage being voided or rescinded.

Name

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

Your Signature:

Today's Date: / /

If you are the authorized representative, you must provide the following information:

Name:

Address:

Phone Number: - -

Relationship to Enrollee:

Office Use Only:

Name of Staff member (if assisted in enrollment):

Plan ID#

PBP# ☐ H2150-801 ☐ H2150-805 ☐ H2150-806 ☐ H2150-807
☐ H2150-017 ☐ H2150-030 ☐ H2172-802 ☐ H2172-805

Group Number Subgroup Number

Employer Subsidy Group ☐ Yes ☐ No

Part D Group ☐ Yes ☐ No

☐ IEP ☐ AEP ☐ SEP (type)

You must continue to pay your Part B premium. In the District of Columbia, Kaiser Permanente is an HMO plan with a Medicare contract. In Maryland, Kaiser Permanente is a Cost plan and an HMO plan with a Medicare contract. In Virginia, Kaiser Permanente is a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-888-777-5536** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-777-5536** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-777-5536** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-777-5536**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-777-5536** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-777-5536** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-888-777-5536 (TTY: **711**)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-777-5536** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-777-5536（TTY:**711**）まで、お電話にてご連絡ください。

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-777-5536** (TTY: **711**).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-888-777-5536 (TTY: **711**) पर कॉल करें।

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-777-5536** (መስማት ለተሳናቸው: **711**).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: **711**) **1-888-777-5536** تماس بگیری

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-777-5536** (رقم هاتف الصم والبكم: -**711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-777-5536** (TTY: **711**).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-777-5536** (ATS : **711**).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o.
E pe ero ibanisoro yi **1-888-777-5536** (TTY: **711**).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-777-5536** (TTY: **711**).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-777-5536** (TTY: **711**).

Bengali

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-888-777-5536** (TTY: **711**)।

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-888-777-5536** (TTY: **711**).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-777-5536** (TTY: **711**).

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-777-5536** (TTY: **711**).