

California Region Kaiser Permanente Group Enrollment Form

Please print or type in black ink only. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER:		
District Name:	Hire Date (mm/dd/yyyy)	
Medical Group Number:	Enrollment Unit:	Effective Enrollment Date (mm/dd/yyyy)
Complete this section ONLY if dental, vision and/or life insurance is offered through SISC: Delta Dental Group#: _____ Vision Group#: _____ SISC Life Ins Group#: Employee Only _____		

A. ENROLLMENT: New group: Yes No

New Hire (complete sections A, B, C, D) Full Time Part Time Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) HMO Plan Deductible Plan Other

Loss of Other Coverage (complete sections A, B, C, D) Other (please specify) _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known)	Social Security No.	Gender M <input type="checkbox"/>	F <input type="checkbox"/>
Name (Last, First, MI)	Birth Date (mm/dd/yyyy)		
Home Address	City	State	ZIP
Work Phone	Home Phone	Email	
Ethnicity	Preferred Language		

C. FAMILY For additional dependents attach a separate sheet with employee's name at top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision Spouse/domestic partner name: _____ Gender: Male _____ Female _____	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision Dependent name: _____	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision Dependent name: _____	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vision Dependent name: _____	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? Yes No If yes, complete the following:
Name (Last, First, MI): _____ Address: _____

D. Kaiser Foundation Health Plan Arbitration Agreement
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Signature required for all Kaiser Permanente Plans **Date**
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

*Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.



Kaiser Permanente Senior Advantage (HMO)

Election form

Northern California or Southern California Region Group Plan

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call our Member Services Contact Center at **1-800-443-0815 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign the form on page 5 and date it. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:
Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Last Name [] First Name []

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.

Name (as it appears on your Medicare card): []

Medicare Number: []

Is Entitled To: HOSPITAL (Part A) [] / [] / []

MEDICAL (Part B) [] / [] / []

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you or your spouse work? [] Yes [] No

2. If your employer provides retiree coverage, are you the retiree? [] Yes [] No [] N/A

If yes, retirement date (mm/dd/yyyy): [] / [] / []

If no, name of retiree: []

Retirement date (mm/dd/yyyy): [] / [] / []

3. Are you covering a spouse or dependents under this employer or union plan? [] Yes [] No

If yes, name of spouse: []

Name(s) of dependent(s): []

4. Do you have End-Stage Renal Disease (ESRD)? [] Yes [] No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

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 that coverage.

Name of other coverage: []

ID # for other coverage: []

Last Name [] First Name []

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: [] - [] - []

7. Requested effective date (subject to CMS approval): [] / [] / []

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

[] Spanish [] Large Print [] Braille [] CD

Please contact Kaiser Permanente at 1-800-443-0815 if you need information in an 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.

Please complete the information below

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name: []

Employer Group/Union/Trust Fund ID #: [] Subgroup: [] Requested effective date (subject to CMS approval): [] / [] / []

Please Read and Sign Below

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

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling 1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Last Name

First Name

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency, urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage **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.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

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 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 if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State 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 from Medicare.

Last Name [] First Name []

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims procedure regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature: []

Today's Date: [] / [] / []

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

Name: []

Address: []

Phone Number: [] - [] - [] Relationship to Enrollee: []

Office Use Only: Name of staff member/agent/broker (if assisted in enrollment): [] Plan ID #: [] Effective Date of Coverage: [] / [] / [] ICEP/IEP: [] AEP: [] SEP (type): [] Not Eligible: []

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 **1-800-443-0815** (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 One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 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**, **800-537-7697** (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 **1-800-443-0815** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-443-0815** (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 **1-800-443-0815** (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 **1-800-443-0815** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-443-0815** (TTY: **711**)번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ջանգահարեք **1-800-443-0815** (TTY (հեռատիպ) **711**):

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (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。 **1-800-443-0815** (TTY:**711**) まで、お電話にてご連絡ください。

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-443-0815** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អិត គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815** (TTY: 711)។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-443-0815** (TTY: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-443-0815** (TTY: 711) पर कॉल करें।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-0815** (TTY: 711).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-443-0815** (TTY: 711) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم - **1-800-443-0815** (رقم هاتف الصم والبكم: 711).