KAISER PERMANENTE®

Kaiser Permanente Senior Advantage (HMO)
ENROLLMENT FORM
Northern California Region or Southern California Region Group Plan

IMPORTANT INFO – Read *all* pages before signing this form

Complete and return this form to become a Kaiser Permanente Senior Advantage (HMO) member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this enrollment form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B. You must live inside our Senior Advantage service area to enroll. Check the ZIP codes/counties listed in the *Evidence of Coverage* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
  - You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Northern California region or the Southern California region, and you are enrolling during an allowable enrollment period. To be eligible, there must be no break in coverage between your current Kaiser Permanente coverage and the start of your coverage in our Senior Advantage plan.
  - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
  - You've had a successful kidney transplant and you attach a note or records from your doctor showing that you've had a kidney transplant and no longer need regular dialysis.
  - You belong to an employer group or union/trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- After completing pages 1-3, read the sections titled "Release of Information" and "Conditions of Enrollment" at the end of this form. Then sign and date page 3.
- Keep the bottom white copy of this form. If required, send the middle yellow copy to your employer group or union/trust fund. Return the top, signed white copy in the enclosed postage-paid envelope to:

  Kaiser Permanente – Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400

- We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
- We'll notify Medicare that you've applied to join Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

COMPLETE THE REQUIRED FIELDS BELOW

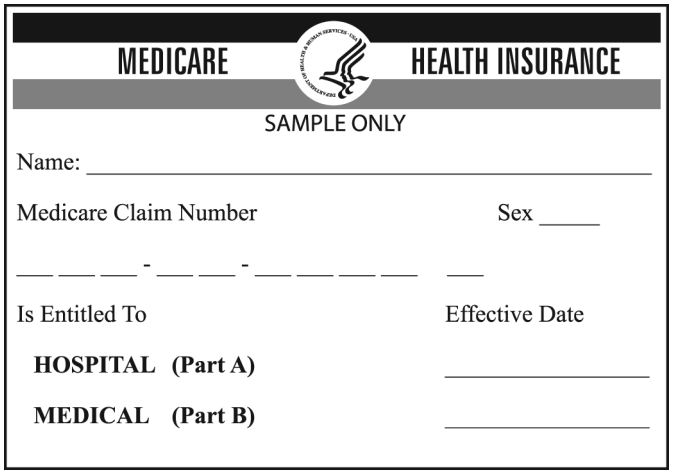
Last Name	First Name	Middle Initial	Gender ☐ M ☐ F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt #
County	City	State	ZIP
Mailing address (if different from permanent residence)			Apt #
County	City	State	ZIP
Daytime phone number	Evening phone number		Date of Birth
Providing the following information is optional:			
E-mail address			
Other contact: Name			Phone number

MEDICARE HEALTH INSURANCE CARD (REQUIRED INFO)

Complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from Social Security or the Railroad Retirement Board) that provides the same information.

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



Last Name: _____ First Name: _____

ADDITIONAL REQUIRED INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No
   If yes: ☐ Current ☐ Former Kaiser Permanente Medical Record Number _____
2. Do you currently have end-stage renal (kidney) disease? ☐ Yes ☐ No
   If yes, provide: Diagnosis date (mm/dd/yyyy) ____ / ____ / _____
   Transplant date ____ / ____ / _____
   See the section titled "Important info" on the cover page for more information about enrolling with ESRD.
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, provide: Date of admission ____ / ____ / _____
   Name of institution _____ Phone _____
   Address _____ City _____ State _____ ZIP _____

4a. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? ☐ Yes ☐ No
   If no, are you retired? ☐ Yes Retirement date ____ / ____ / _____

4b. Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? ☐ Yes ☐ No
   If yes, provide name of spouse's employer _____

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Senior Advantage? ☐ Yes ☐ No
   If yes, list other coverage and ID number(s) for this coverage:
   Name of other coverage _____
   ID# for this coverage _____ Group # for this coverage _____

☐ Check here if you prefer to receive info in Spanish

This information is available in a different format or in Spanish by calling **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

Puede obtener esta información en un formato diferente o en español llamando al **1-800-443-0815** (TTY **1-800-777-1370**), los siete días de la semana, de 8 a.m. a 8 p.m.

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID# _____ Subgroup _____

Requested effective date (subject to CMS approval) ____ / ____ / _____

Last Name: _____ First Name: _____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in 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 contained in the *Evidence of Coverage*.

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 any 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.

READ "CONDITIONS OF ENROLLMENT" BEFORE SIGNING AND DATING BELOW (REQUIRED INFO)

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 enrollment form means that I have read and understand the contents of this enrollment form. 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.

Signature of applicant *or*
signature of authorized representative _____ Date ____ / ____ / _____

Authorized representative name (please print) _____ Relationship _____

Address _____ Phone _____

Signature of any person who
assisted in completing this form _____ Date ____ / ____ / _____

INTERNAL USE ONLY

Date _____ Lang Pref _____

Rep _____ ☐ IEP ☐ ICEP ☐ AEP ☐ SEP

CONDITIONS OF ENROLLMENT – By completing this form, I agree to the following:

1. I will read the Senior Advantage *Evidence of Coverage (EOC)* when I get it to know which rules I must follow in order to get coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente is a health plan with a Medicare contract.
3. I must maintain my enrollment in Medicare Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. 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 trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.
6. It's my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not 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.
8. I understand that I must enroll in the Senior Advantage service area in which I reside. I understand that it's my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than six months in a row.
9. 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.
10. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Senior Advantage *EOC* for more information about covered benefits and services. 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. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente 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.
11. Once I become a member of Senior Advantage, I have the right to appeal plan decisions about payment/services.
12. 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.
13. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
14. If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

If you currently have health coverage from an employer or union/trust fund, joining Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Advantage. Read the communications your employer or union/trust fund sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any info on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form.