Group Election Request Form

Group Plan | Kaiser Permanente Medicare Advantage HMO

Washington Region

KAISER PERMANENTE®

Employer Group Use Only

Optional Group Stamp Area:

Employer Group #:

Employer Receipt Date: (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Authorized Rep:

This application is for Kaiser Permanente Employer Group (HMO) plans offered in the following counties: Grays Harbor (partial), Island, King, Kitsap, Lewis, Mason (partial), Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom.

Please contact Kaiser Permanente if you need information in another language or format (Braille).

Last Name

First Name

To enroll in Kaiser Permanente Medicare Advantage, please provide the following information:

Employer or Union Name:

Group #:

LAST Name:

☐ Mr. ☐ Mrs. ☐ Ms.

FIRST Name:

Middle Initial:

Sex:
☐ Male ☐ Female

Home Phone Number:
- -

Alternate Phone Number:
- -

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

Are you a current or former member of any Kaiser Permanente health plan?
☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

Permanent Residence Street Address (P.O. Box is not allowed):

City:

County:

State:

ZIP Code:

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

Street Address:

City:

State:

ZIP Code:

E-mail Address:

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:	Effective Date:
HOSPITAL (Part A)	/ /
MEDICAL (Part B)	/ /

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

Last Name _____ First Name _____

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 (month/day/year):
   ☐☐/☐☐/☐☐☐☐

   If no, name of retiree:
   _____

   Retirement date (month/day/year):
   ☐☐/☐☐/☐☐☐☐

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):
/ /

Selecting a primary care provider:
If you have a current primary care provider who contracts with Kaiser Foundation Health Plan of Washington (primary care providers do not include specialists) and you would like to continue seeing that physician, please include their name here.

(If you are a current Kaiser Permanente member and are not making a primary care provider change, please leave blank.)

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

☐ Large Print ☐ Braille ☐ CD

Please contact Kaiser Permanente at **1-888-901-4600** if you need information in another format. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **1-800-833-6388 or 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 Kaiser Permanente Medicare 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):
/ /

Last Name _____ First Name _____

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 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 Kaiser Permanente Medicare Advantage plan because I can be enrolled in only one Kaiser Permanente Medicare 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 Kaiser Permanente Medicare Advantage plan.

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 **Kaiser Permanente Medicare 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 Kaiser Permanente Medicare 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 **Kaiser Permanente Medicare 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.

Last Name First Name

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.

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:

Last Name

First Name

Agent Use Only:

Receipt Date / /

Released to client on / /

Effective Date of coverage Month

☐ ICEP/IEP ☐ AEP ☐ Not eligible

☐ SEP (reason if SEP)

Appointment type

Scope of Appointment attached
☐ Yes ☐ No

Name of Kaiser Permanente staff member

Broker or agent name

Kaiser Permanente agent ID number

Company/house name (if applicable)

Kaiser Permanente house ID number

Phone number
- -

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Kaiser Permanente:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente Member Services.

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, sex, sexual orientation, or gender identity, you can file a grievance by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge. The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Fax: 206-901-6205 or toll-free 1-888-874-1765
Address: Kaiser Foundation Health Plan of Washington
Civil Rights Coordinator, Quality GNE-D1E-07
P.O. Box 9812
Renton, WA 98057-9054
Email: csforms@ghc.org

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

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(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 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ បេយ័តន៖** បើសិនអកនិយាខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូរស័ព 1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (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。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.