Kaiser Foundation Health Plan of Washington Medicare Advantage (HMO) election form

KAISER PERMANENTE®

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 print clearly using black or blue ink only. Required fields are indicated with an asterisk (*).

1. PLAN INFORMATION*

Employer or union name_____ Group number _____

Requested effective date (subject to Medicare guidelines):

What effective date are you requesting? (Month): _____-01-2017

2. MEDICARE INFORMATION

Please fill in the information at right exactly as it is on your Medicare card.

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

MEDICARE HEALTH INSURANCE

Last name*

_____

First name* MI*

_____

Medicare claim number*

_____

Is entitled to	Effective date
Hospital (Part A)	_____
Medical (Part B)	_____

3. PERSONAL & CONTACT INFORMATION

Date of birth*_____ Sex* ☐ Male ☐ Female ☐ Mr. ☐ Mrs. ☐ Ms.

Kaiser Permanente member # (if applicable) _____

Permanent **residential** street address* (do not use a P.O. Box or a mail delivery service)

_____

_____ Length of time at this address _____

City_____ County_____ ST _____ ZIP _____

Mailing address (if different from above)

_____

_____

City _____ ST _____ ZIP_____

Contact information

Telephone (primary) _____ Telephone (secondary) _____

A. Best time to reach you ☐ Morning ☐ Afternoon ☐ Evening

B. If we need additional information in order to complete the processing of this election form, may we use email to communicate with you? ☐ Yes ☐ No If yes, email address:

_____

4. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

A. Do you currently have End-Stage Renal Disease (ESRD)—permanent kidney failure requiring kidney dialysis or a transplant to stay alive?* ☐ **Yes** ☐ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, 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.

B. 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 Medicare Advantage (HMO)? ☐ **Yes** ☐ **No**

If yes, name of other coverage _____

ID # for coverage _____

C. Do you live in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

If yes, name of facility _____

Address of facility _____

Phone number of facility _____

Date admitted _____

D. Are you enrolled in a state Medicaid program? ☐ **Yes** ☐ **No**

If yes, Medicaid number _____

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):

5. BY COMPLETING THIS FORM, I AGREE TO THE FOLLOWING:

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente HMO depends on contract renewal. You will need to keep your Medicare Parts A and B. You must continue to pay your Medicare Part B premium. Enrollment in this plan is generally for the entire year. Once you enroll, you 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), or under certain special circumstances.

The Kaiser Permanente Medicare Advantage (HMO) plan serves a specific service area. If you move out of the area that the Medicare Advantage (MA) plan serves, you need to notify the plan so you can disenroll and find a new plan in your new area. Once you are a Kaiser Permanente MA plan member, you have the right to appeal plan decisions about payment or services if you disagree. Read your plan's Evidence of Coverage from Kaiser Permanente when you receive it to learn which rules you must follow in order to get coverage with this MA plan. People with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Beginning on the date your Kaiser Permanente Medicare Advantage (HMO) coverage begins, you must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis.

Those services authorized by Kaiser Permanente and other services contained in your plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If you obtain routine care from out-of-network providers without authorization, **neither Medicare nor Kaiser Permanente will pay for the services**.

If you are receiving assistance from a Kaiser Permanente sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on your enrollment in a Kaiser Permanente Medicare Advantage (HMO) plan.

NOTE: You can only be in one Medicare Advantage plan at a time, and understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan. It is your responsibility to inform Kaiser Permanente of any prescription drug coverage that you have or may get in the future.

RELEASE OF INFORMATION:

By joining this Medicare Advantage health plan, I acknowledge that Kaiser Foundation Health Plan of Washington will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Kaiser Foundation Health Plan of Washington will release my information including my prescription drug event data (if I join a Medicare Advantage plan with prescription drug benefits) 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 by Kaiser Foundation Health Plan of Washington or by Medicare.

Your signature* _____ **Date** _____

If you are the authorized representative, you must sign above and provide the following information.*
Proof of your authority must be presented to Kaiser Permanente or to Medicare upon request.

Name_____ **Phone** _____

Relationship to applicant _____

Address _____

_____

Please return all pages

ONE LAST THING

Please return all pages of this election form.

Completed election form can be sent to:

Kaiser Permanente Medicare Enrollment, ANB-2
P.O. Box 34255
Seattle, WA 98124-1255

Or, fax to **206-988-7543**.

QUESTIONS

This information is available in an alternate format such as Braille, larger print, or audio. To obtain information or to ask questions regarding this election form, please call Member Services.

This information is available for free in other languages. Please call our Member Services number at **1-888-901-4600**. (TTY users should call **1-800-833-6388** or **711**.) Hours are Monday–Friday from 8 a.m. to 8 p.m. From October 1 to February 14, call 7 days a week from 8 a.m. to 8 p.m.

THIS PAGE LEFT BLANK INTENTIONALLY

AGENT USE ONLY

Receipt date_____ **Released to client on** _____

Effective date of coverage _____**-01-2017**
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 Date-Stamp:

kp.org/wa/medicare

KAISER PERMANENTE®

MA0001638-50-17