

GROUP/FEHB ENROLLMENT FORM

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

2101 East Jefferson Street, Rockville, MD 20852



KAISER PERMANENTE®

kp.org/medicare

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 Plus member. 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 **1-866-513-0008** before signing this form.

ELIGIBILITY

1. You may not enroll in Kaiser Permanente Medicare Plus if you currently have End-Stage Renal Disease (ESRD) unless:

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

2. We need verification that you are enrolled in Medicare Part B and that you live within our Kaiser Permanente Medicare Plus service area for us to enroll you. Please check the ZIP code listing in the Provider Directory to be sure you qualify for enrollment.

ABOUT THE ENROLLMENT PROCESS – Submitting your enrollment form

- 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.
 - Please **print** your answers and use only **black or blue ink**.
 - Be sure to select a **primary care physician** from our Provider Directory or online at **kp.org/doctor**. If you do not select a primary care physician, we will select one for you. You may change your primary care physician anytime.
 - 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 for Medicare Parts A and B or Part B only. 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 Plus 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 _____
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To Enroll in Kaiser Permanente Medicare Plus, Please Provide the Following Information:

A

Please indicate your requested enrollment effective date ___/___/___
(MM/DD/YYYY)

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date (___/___/___) (MM/DD/YYYY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number ()
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Permanent Residence Street Address

City	State	County	ZIP Code
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Mailing Address (only if different from your Permanent Residence Address)

Street Address

City	State	ZIP Code
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E-mail Address

Employer Name

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 Plus 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 Plus 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.

Warning DC/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 is guilty of a crime and may be subject to fines and confinement in prison.

Name _____ Kaiser Permanente
 Medical Record Number _____

Please Provide Your Medicare Insurance Information

B

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

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

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

Please read and answer these important questions:

C

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
 Do you have health coverage through your or your spouse's current or former employer? 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 ____/____/_____
 (M M / D D / Y Y Y Y)
 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 Medicare Plus? 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 _____
- If "no," and you previously had prescription drug coverage, when did it end? ____/____/_____
 (M M / D D / Y Y Y Y)

Name _____	Kaiser Permanente Medical Record Number _____
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5. Please choose the name of a Primary Care Physician (PCP) and enter the provider code and name here:

PCP Provider Code # _____ Name _____

Is this your current PCP? Yes No

6. 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 _____



Please Read the Following and Sign on Page 5:

D

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

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 Medicare Plus 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 Plus/FEHB members only: I understand if I disenroll from Kaiser Permanente Medicare Plus for Federal Employees, it means ending my membership in Kaiser Permanente Medicare Plus 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 Plus serves a specific service area. If I move out of the area that Kaiser Permanente Medicare Plus 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 Kaiser Permanente non-Medicare 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 Kaiser Permanente Medicare Plus, 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 Medicare Plus when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

I understand that beginning on the date Kaiser Permanente Medicare Plus coverage starts, in order for Kaiser Permanente Medicare Plus to fully cover my medical services (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.

Name _____	Kaiser Permanente Medical Record Number _____
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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 Medicare Plus and other services contained in my Kaiser Permanente Medicare Plus *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 Medicare Plus 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.

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 Medicare Plus 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 _____

Name _____	Kaiser Permanente Medical Record Number _____
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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

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. Kaiser Permanente is a Cost Plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

White and yellow copies: Please return pages 1 - 5 to Kaiser Permanente • Pink copy: Please keep for your records