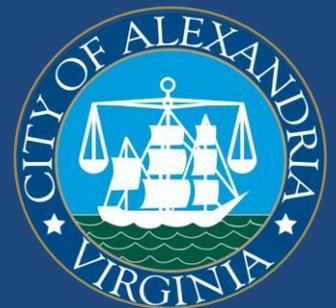


RETIREE GUIDE TO FY 2014 OPEN ENROLLMENT PERIOD

This year's Open Enrollment period begins on May 9, 2013 and ends May 24, 2013. During this time, you may change your health insurance coverage.



Open Enrollment Guide

<p>What do I do if I'm satisfied with my current benefit plan choices?</p>	<p>If you are satisfied with your current plans, you need do nothing more!</p>
<p>If I want to make a change, what benefit plan choices can I make during Open Enrollment?</p>	<p><u>Health Insurance Plans:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Options to enroll, change, or drop your healthcare coverage. <input type="checkbox"/> 3 Plans available in FY 2014 with individual, Retiree + 1, and Family coverage options: <ol style="list-style-type: none"> 1. Kaiser HMO 2. United Healthcare Choice Plan (HMO) 3. United Healthcare Choice Plus Plan (PPO) <p>Note: Effective July 1, 2013, the Kaiser POS plan will no longer be available.</p> <p>Note: If you will <u>attain age 65</u> in 2013 please contact the Benefits Team at 703-746-3777 for details regarding the Kaiser Medicare Plus Plan or other post-65 options. The plan year for this plan runs January 1st through December 31st.</p>
<p>What should I do if I'm considering a change to my benefits plan?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review the packet you received by mail from HR that includes a letter, the <i>Guide to FY 2014 Open Enrollment</i>, and benefit enrollment forms. <input type="checkbox"/> Plan to visit one of the 11 on-site meetings scheduled to be held throughout the City during Open Enrollment so the health insurance carriers can answer your personal, unique questions/concerns. A schedule of dates/times is included on the next page. <input type="checkbox"/> Contact the HR Benefits Team at 703-746-3777.
<p>What is the deadline to make a change to my benefits plans?</p>	<p>The Open Enrollment period is Thursday, May 9 through Friday, May 24, 2013.</p> <ul style="list-style-type: none"> <input type="checkbox"/> If you decide to <u>enroll, change or drop</u> plan or tier, complete the appropriate enrollment form (included in this packet) and return it to Human Resources no later than 4:30 pm on Friday, May 24th so it is processed timely. <input type="checkbox"/> Enrollment forms can be submitted in-person or mailed to the address listed below: <p style="text-align: center;">City of Alexandria Human Resources Department 301 King Street, Room 2510 Alexandria, VA 22314 Attn: Benefits Team</p>
<p>Who can help me if I still have questions or need assistance with my choices?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Visit one of the 11 on-site meetings scheduled to be held throughout the City during Open Enrollment (<i>see next page for schedule</i>) so the health insurance carriers can answer your personal, unique questions/concerns. <input type="checkbox"/> Contact the HR Benefits Team Monday-Friday, 8:00AM – 5:00PM at (703) 746-3785.

Open Enrollment On-Site Meetings

SCHEDULE OF OPEN ENROLLMENT ON-SITE MEETINGS

The FY 2014 Open Enrollment Period for the City's health and dental insurance plans, long term disability and sick leave bank will be held from **May 9 - May 24, 2013**. During this time, benefit eligible City employees and retirees will have the opportunity to review and discuss plan benefits with representatives from Dominion Dental, Kaiser Permanente and United HealthCare. Representatives will also be available to answer specific questions about the healthcare plan design changes and explain how the new deductibles will work.

Representatives from the City's health insurance carriers will be available at the scheduled "walk-in" enrollment meetings listed below. Please do not bring personal medical records or information to these sessions. Carriers will provide samples of the fees charged for many of the most common services provided to you.

<u>DATE</u>	<u>TIME</u>	<u>LOCATION</u>
Thursday, May 9	6:00 a.m. - 9:00 a.m.	T&ES 2900 B Business Center Drive Suite B
Friday, May 10	9:00 a.m. –11:00 a.m.	City Hall 301 King Street (Room 2000)
Monday, May 13	9:00 a.m. – 11:00 a.m.	Nanny Lee 1108 Jefferson Street (Gold Room)
Monday, May 13	1:00 p.m. – 3:00 p.m.	Beatley Central Library 5005 Duke Street
Tuesday, May 14	4:00 p.m. – 7:00 p.m.	Public Safety (Police) 3600 Wheeler Ave Suite 120A
Thursday, May 16	9:00 a.m. – 2:00 p.m.	Health, Wellness and Benefits Fair Charles Houston Recreation Center 901 Wythe Street
Friday, May17	1:00 p.m. – 3:00 p.m.	Dept. of Community & Human Services 2525 Mt. Vernon Avenue Atrium Conference Room
Monday, May 20	9:00 a.m. – 11:00 a.m.	DCHS (Joblink) 1900 N. Beauregard St.
Tuesday, May 21	1:00 p.m. – 3:00 p.m.	Dept. of Community & Human Services 720 N. St. Asaph Street 4 th Floor, Conference Room
Wednesday, May 22	6:00 a.m. – 9:00 a.m.	Public Safety (Fire) 900 Second Street (2 nd Floor)
Thursday, May 23	6:00 a.m. – 9:00 a.m.	Public Safety (Sheriff) 2003 Mill Road

Common Health Insurance Terms

COMMON HEALTH INSURANCE TERMS DEFINED

Copayment (copay): This is a specific amount you pay when you receive certain covered services or prescriptions. Copayments vary depending on the plan and the service.

- **In-Network copays** are fixed amounts you pay for covered services to providers who contract with your health insurance plan and are usually less than out-of-network copays.
- **Out-of-Network copays** are fixed amounts you pay for covered services from providers who do *not* contract with your health insurance plan and are usually more than in-network copays.

Deductible: A fixed amount you pay out of pocket before a health insurance plan begins to cover your health care costs.

Emergency Room: Typically, emergency room services include all services provided when a patient visits an emergency room for an emergency condition. An emergency condition is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in ***serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.***

Out-Of-Pocket Maximum (Costs): The most you pay in a plan year before your health insurance plan begins to pay 100% of the allowed amount. This limit never includes your premium and the design of a healthcare plan will determine if all, some, or none of your copays, deductibles, co-insurance, etc. count towards the limit.

Premium: The fixed amount that you will pay every month for health insurance coverage usually deducted from your biweekly paychecks.

Preventive Care: Medical care rendered not for a specific complaint, but focused on prevention and early-detection of disease. Specified by your plan, preventive care generally includes screening exams, routine preventive physical exams for adults and children, prenatal care, and vaccines (immunizations).

Primary Care Physician (PCP): A patient may be required to choose a primary care physician (PCP). A primary care physician usually serves as a patient's main healthcare provider. The PCP serves as a first point of contact for healthcare and may refer a patient to specialists for additional services.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Sources:

- <http://www.ehealthinsurance.com/health-insurance-glossary/terms-e/>
- <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>
- https://healthy.kaiserpermanente.org/static/health/en-us/landing_pages/continuingcoverage/glossary.htm
- http://www.uhc.com/source4women/understanding_health_coverage/common_terms_defined.htm

Health Insurance

CHANGES TO YOUR HEALTH INSURANCE BENEFITS IN FY 2014

The City will transition to a new consumer-driven health insurance model beginning July 1, 2013. This new model will not change your coverage. Your policy will cover the same services, procedures, tests, visits, and medications as before.

As you can see from the chart below, the plan design changes introduce a deductible that must be satisfied before health care benefits start. In addition, there is a new co-payment for in-network hospital visits and increased co-payments for Emergency Room and Urgent Care visits.

Plan Features	Current FY 2013 Plans		FY 2014 Plans
Deductibles	None		\$400/Individual \$800/Family (Includes Employee +1)
Annual Out-of-Pocket Maximum			Includes Deductible
<ul style="list-style-type: none"> • Individual • Family 	\$2,200		\$2,200
	\$6,400		\$6,400
Preventive Care	Covered in Full		Covered in Full
PCP/Specialist Copay	\$15/\$25		Deductible + \$15/\$25
Emergency Room Copay	\$75		Deductible + \$150 copay
Inpatient Hospitalization Copay	Covered in Full		Deductible + \$500/admittance
Urgent Care Copay	\$15		Deductible + \$25 copay
Retail Prescription Drugs Copay	<u>Kaiser</u>	<u>UHC</u>	<u>All Plans</u>
<ul style="list-style-type: none"> • Generic • Brand Preferred • Brand Non-Preferred 	\$10	\$10	\$15
	\$20	\$25	\$30
	\$35	\$40	\$50
Mail Order	2xRetail	1xRetail	2.5xRetail
			After 3 rd refill, mail order is mandatory

Health Insurance

FY 2014 HEALTH INSURANCE PREMIUM RATES FOR RETIREES

The table below lists the monthly health insurance premium rates paid by the City and retirees. There is no change in FY 2014 to the monthly retiree health insurance reimbursement subsidy of up to \$260.

RETIREES

SEE PAGES 6 & 7 FOR PREMIUM RATE CHARTS

Kaiser Permanente

		HMO (In Plan Coverage Only)					POS Coverage (In Plan or out of Plan Coverage)				
		TOTAL COST	CITY COST	CITY % OF COST	RETIREE COST	RETIREE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	RETIREE COST	RETIREE % OF COST
Kaiser Permanente Under 65 Individual	Monthly Premium	\$477.83	\$260.00	54.41%	\$217.83	45.59%					
	Retiree + One										
	Monthly Premium	\$914.04	\$260.00	28.45%	\$654.04	71.55%					
Family	Monthly Premium	\$1,433.49	\$260.00	18.14%	\$1,173.49	81.86%					
	Kaiser Permanente Over 65 Individual										
Monthly Premium	\$208.55	\$260.00	100.00%	\$0.00	0.00%						
Retiree + One (Both Medicare)	Monthly Premium	\$417.00	\$260.00	62.35%	\$157.00	37.65%					
	Retiree + One (One Medicare, One Not)										
Monthly Premium	\$681.70	\$260.00	38.14%	\$421.70	61.86%						

Plan will not be offered in FY 2014*

*Kaiser has informed the City that due to the plan design changes enacted in FY 2014 it will be unable to support the POS plan offered to employees and retirees in FY 2013. With the discontinuation of the POS plan, employees and retirees enrolled in the Kaiser POS plan in FY 2013 will be required to select a new City sponsored plan, or drop their coverage, during the FY 2014 open enrollment period which will take place in May 2013.

United Health Care

	HMO (In Plan Coverage Only)				POS Coverage (In Plan or out of Plan Coverage)					
	TOTAL COST	CITY COST	CITY % OF COST	RETIREE COST	RETIREE % OF COST	TOTAL COST	CITY COST	CITY % OF COST	RETIREE COST	RETIREE % OF COST
United Health Care Under 65 Individual	UHC Choice (In Plan Coverage Only)									
Monthly Premium	\$578.40	\$260.00	44.95%	\$318.40	55.05%	\$686.81	\$260.00	37.86%	\$426.81	62.14%
Retiree + One Monthly Premium	\$1,108.26	\$260.00	23.46%	\$848.26	76.54%	\$1,314.33	\$260.00	19.78%	\$1,054.33	80.22%
Family Monthly Premium	\$1,738.14	\$260.00	14.96%	\$1,478.14	85.04%	\$2,060.42	\$260.00	12.62%	\$1,800.42	87.38%
United Health Care Over 65 Individual	Choice Plus Coverage >65 (In Plan or Out of Plan Coverage)									
Monthly Premium	\$520.96	\$260.00	49.91%	\$260.96	50.09%	\$617.55	\$260.00	42.10%	\$357.55	57.90%
Retiree + One Monthly Premium	\$1,080.97	\$260.00	24.05%	\$820.97	75.95%	\$1,281.37	\$260.00	20.29%	\$1,021.37	79.71%
Family Monthly Premium	\$1,746.73	\$260.00	14.88%	\$1,486.73	85.12%	\$2,135.61	\$260.00	12.17%	\$1,875.61	87.83%

Health Insurance

FY 2014 COMPARISON OF HEALTH INSURANCE PLAN FEATURES

(For Period July 1, 2013 through June 30, 2014)

To help in your review of key benefits included in each of the plans, please see the comparison chart below:

Covered Benefits	Kaiser DHMO	United Healthcare Choice (HMO)	United Healthcare Choice Plus (PPO)	
			In-Network	Out-of-Network
Deductible	\$400 Individual \$800 Family*	\$400 Individual \$800 Family*	\$400 Individual \$800 Family*	\$800 Individual \$1600 Family
Out-of-Pocket Maximum	\$2200 Individual \$6400 Family	\$2200 Individual \$6400 Family	\$2800 Individual \$8600 Family	\$2800 Individual \$8600 family
Primary Care Office Visit for Illness	\$15 Copay \$0 Copay for Children under age 5	\$15 Copayment	\$15 Copayment	80% coinsurance
Specialist Office Visit for Illness	\$25 Copay	\$25 Copayment	\$25 Copayment	80% Coinsurance
X-ray, Lab, and Diagnostics (Outpatient)	\$0 Copay	100%	100%	80% Coinsurance
X-ray, Lab, and Major Diagnostics (CT, PET, MRI, MRA and Nuclear Medicine (Outpatient))	\$75 Copay	\$100 Copayment per service	\$100 Copayment per service	80% Coinsurance
Inpatient Hospitalization	\$500 Copay	\$500 Copayment per admit	\$500 Copayment per admit	80% Coinsurance
Emergency Room Copay	\$150 Copay**	\$150 Copayment per visit**	\$150 Copayment per visit**	\$150 Copayment per visit**
Urgent Care Copay	\$25 Copay	\$25 Copayment	\$25 Copayment	80% Coinsurance
Mental Health and Substance Abuse Services-Inpatient/Intermediate	\$500 Copay	\$500 Copayment per admit	\$500 Copayment per admit	\$500 Copayment per admit, 80% Coinsurance
Mental Health and Substance Abuse Services-Outpatient	\$15 Copay Individual \$7 Copay Group	\$15 Copayment	\$15 Copayment	80% Coinsurance
Pregnancy/Maternity Services	\$15 Initial visit, then \$0 copay	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category, 80% Coinsurance
Preventive Care				
Well Child Care	Covered in full	Covered in full	Covered in full	80% Coinsurance
Adult Physical Exam	Covered in full	Covered in full	Covered in full	80% Coinsurance
Routine GYN Visit	Covered in full	Covered in full	Covered in full	80% Coinsurance
Mammogram	Covered in full	Covered in full	Covered in full	80% Coinsurance
Cancer Screening (Pap Test, Prostate)	Covered in full	Covered in full	Covered in full	80% Coinsurance

Health Insurance

FY 2014 COMPARISON OF HEALTH INSURANCE PLAN FEATURES CONTINUED

(For Period July 1, 2013 through June 30, 2014)

Covered Benefits	Kaiser DHMO	United Healthcare Choice (HMO)	United Healthcare Choice Plus (PPO)	
			In-Network	Out-of-Network
Prescription Drug Coverage¹				
Generic Brand² (Lowest-Cost)	\$15 Medical Center, \$25 Participating Community Pharmacy	\$15 Copayment	\$15 Copayment	80% Coinsurance
Preferred Brand (Mid-Range Cost)	\$30 Medical Center \$40 Participating Community Pharmacy	\$30 Copayment	\$30 Copayment	80% Coinsurance
Non-Preferred Brand (Highest Cost)	\$50 Medical Center \$55 Participating Community Pharmacy	\$50 Copayment	\$50 Copayment	80% Coinsurance
Mail Order	Generic: \$13 Preferred: \$23 Non-Preferred: \$38	Mandatory mail order after 3 rd fill at retail	Mandatory mail order after 3 rd fill at retail	Mandatory mail order after 3 rd fill at retail

* Includes Employee + 1

**Waived if admitted

¹ If you choose a non-preferred brand name drug instead of the generic equivalent, you will pay the highest copay plus the difference in cost between the non-preferred brand name and the generic. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for a brand name and DAW (dispense as written) is noted on the prescription, you will only pay the copay.

² Prescription Drug tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is the amount you will pay when you fill a prescription. Generic medications are your lowest-cost options. If the brand of medication prescribed is Preferred or Non-Preferred, please check with your physician to see if there is a Generic alternative.

NOTE: While increasing use of generics is one way to lower pharmacy costs, not all generics represent the best value. In fact, there are many instances where a generic can be more expensive than a brand and/or other alternative.

When a new generic launches (just following the brand's patent expiration), the first generic manufacturer typically has six months of little to no competition from other generics in the marketplace, known as an exclusivity period. In some cases, pharmaceutical manufacturers will price the generic at a premium to the brand in order to take advantage of pharmacy dispensing practices that automatically favor generics, regardless of cost.

Forms

- Kaiser Permanente Enrollment Form
 - United Healthcare HMO Enrollment Form
 - United Healthcare PPO Enrollment Form
-



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street, Rockville, Maryland 20852

KAISER PERMANENTE ENROLLMENT & CHANGE FORM
HMO PLAN OFFERINGS
INSTRUCTIONS

Table with 2 columns and multiple rows containing enrollment instructions, section headers (Section B: Waiver of Coverage, Section C: Family Information, Section D: Maximum Age/Disabled Dependent, Section E: Dependents residing at another PERMANENT address), and detailed instructions for each section.

	Section G: Subscriber Sign-off
Section F: Other Coverage Information	Review and sign this form. Before you sign this form, please make certain you have read all coverage materials and have selected a primary care provider. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card.
<p>Tell us if you, your spouse, or other family dependents are covered by other group health insurance plans. This may occur when both spouses are employed and have health care benefits from one or more health plan(s). If you or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans.</p> <p>If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners (NAIC) guidelines including , but not limited to; Medicare, Motor Vehicle Insurance (Except Virginia residents and Virginia group employees. Virginia residents and Virginia group employees are not subject to subrogation of a recovery for personal injuries from a third person.), Workers' Compensation, Tricare, Veterans Administration, so long as you are enrolled in the primary plan and such plan remains primary to KFHP – MAS plan. Your signature authorizes KFHP-MAS and its employees to release any records or information with respect to any claim for covered services that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380.</p>	<p style="text-align: center;">MISREPRESENTATION</p> <p>If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties. You may also be liable to KFHP-MAS for the cost of health care services provided because of the false or misleading information or omission.</p>

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM

*Additional documentation will be required.

** May require additional information

**Kaiser Foundation Health Plan of the
Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street, Rockville, Maryland 20852

**KAISER PERMANENTE ENROLLMENT & CHANGE FORM
HMO PLAN OFFERINGS**

If you have any questions concerning the benefits and services that are provided by or excluded under your plan offering, please contact a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 before signing this form.

Please see instructions located at the back of this booklet for directions on how to complete this form. After you have completed this form, please sign and return all pages, including the instructions, to your employer's benefits office. **DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.**

If you are enrolling in our Medicare product, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.

TO BE COMPLETED BY EMPLOYER Please print or type in black ink only.

ENROLLMENT TYPE

NEW CHANGE

EMPLOYMENT STATUS

Active Retired

GROUP NO.

SUBGROUP NO.

THE INFORMATION BELOW IS REQUIRED BY LAW. FAILURE TO COMPLETE WILL RESULT IN A DELAY OF APPLICATION PROCESSING.

CHECK IF NEW HIRE IF NEW HIRE, INDICATE NEW HIRE DATE (MM/DD/YYYY)

EMPLOYEE LAST NAME

FIRST NAME

MI

SUFFIX

Check One and indicate date of event:

New enrollment New enrollment Effective Date (MM/DD/YYYY)

Open enrollment (complete sections A, C, F, G) Open enrollment Effective Date (MM/DD/YYYY)

COBRA (complete sections A, B, E, G) COBRA Effective Date (MM/DD/YYYY)

Loss of other coverage (complete sections A, C, F, G)

Cancel all coverage (empl. and family) (complete sections A, G) Effective Date of Cancellation (MM/DD/YYYY)

EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE

I hereby certify that this(these) enrollment(s) has been reviewed and meet(s) all eligibility requirements

Printed or Typed Name/Title		
Employer Signature		
Date	Telephone	Fax

*Additional documentation will be required.

** May require additional information

B. Waiver of Coverage

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

- All Coverage Coverage for my Spouse
- Coverage for my Children

I understand that if I or my Dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit documentation to support enrollment outside the Open Enrollment period and coverage may be subject to late enrollment provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all appropriate boxes)

- other group coverage sponsored by my employer*
- other group coverage sponsored by my Spouse's employer*
- other group coverage sponsored by another organization*
- other reasons (please explain)

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

ADD DEPENDENTS (Complete sections A, C, F, G)

	Date of Event (MMDDYYYY)		Date of Event (MMDDYYYY)
<input type="checkbox"/> Birth**	□□□□□□□□	<input type="checkbox"/> Loss of other Coverage*	□□□□□□□□
<input type="checkbox"/> Adoption*	□□□□□□□□	<input type="checkbox"/> Marriage*	□□□□□□□□
<input type="checkbox"/> Address (complete sections A, G)		<input type="checkbox"/> Telephone (complete sections A, G)	
<input type="checkbox"/> Name Change* _____ Previous Name _____		<input type="checkbox"/> Other (please specify; Complete sections A, C, G)*	

C. FAMILY INFORMATION (If additional space is needed please use another form and attach it to this form)

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> DOMESTIC PARTNER (If eligible under your plan)
LAST NAME	FIRST NAME	MI	SUFFIX
□□□□□□□□□□□□□□□□	□□□□□□□□□□□□□□	□	□□□□
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE
□□□□□□□□□□	□□□□□□□□□□	□□□□□□□□□□	□ □
Primary Care Provider (PCP) Name _____		PCP ID # □□□□□□□□	

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER _____
LAST NAME	FIRST NAME	MI	SUFFIX
□□□□□□□□□□□□□□□□	□□□□□□□□□□□□□□	□	□□□□
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE
□□□□□□□□□□	□□□□□□□□□□	□□□□□□□□□□	□ □
Primary Care Provider (PCP) Name _____		PCP ID # □□□□□□□□	

*Additional documentation will be required.
** May require additional information

F. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? YES NO

Name	Insurance Carrier Name	Policy Number	Telephone Number
------	------------------------	---------------	------------------

Are you or any of your dependents eligible for Medicare? YES NO

If Yes, please complete the following:

MEDICAID NUMBER

MEDICARE (HIC) NUMBER

MEDICARE Part A Effective Date (MM/DD/YYYY)

MEDICARE Part B Effective Date (MM/DD/YYYY)

MEDICARE Part D Effective Date (MM/DD/YYYY)

G. Important: I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this form is accepted, coverage will be provided according to the terms and conditions of my employer's contract with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

I authorize KFHP-MAs and its employees to release any records or information with respect to any claim for covered services that may be requested by another insurance carrier. Such authorization shall be valid for the duration of coverage.

I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties may include imprisonment and/or fines. In addition, KFHP-MAS may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

Employee/Applicant Signature	Date	Employer Signature	Date

*Additional documentation will be required.

†† May require additional information

Enrollment Application and Change Form

INSTRUCTIONS

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1Complete all information.

SECTION 2Select who should be covered on the plans.

SECTION 3Complete this section if you choose to decline coverage for yourself or any of your dependents.

SECTION 4Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5Fill in the appropriate action code for completing this form:

- A = To add a dependent to your benefit plan
- T = To terminate your or a dependent's coverage
- C = To change information about yourself or a dependent

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked Other Insurance and complete Section 6. Provide the zip code, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is disabled or a full-time student. (If you have more than 4 dependents, please attach an additional enrollment form.)

SECTION 6This section must be completed for all new enrollments or coverage changes.

SECTION 7The employee must sign and date this form in order for it to be processed.

SECTION 8This section is to be completed by the employer's benefit representative.