Start here - Tear and separate pages along the perforated edge before completing

Kaiser Permanente Senior Advantage (HMO)

Group Election Request Form

Northern California or Southern California Region Group Plan

KAISER PERMANENTE®

IMPORTANT INFO – Read all pages before signing this form

Completing and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you will each need to complete a separate form. For help completing this form, call our Member Service Contact Center at **1-800-443-0815**, toll free (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

ABOUT THE ENROLLMENT PROCESS — Submitting your form

1. Remove the perforated tab at the top of the page.
2. Separate all pages BEFORE filling out the form.
3. Fill out the separated pages completely.
4. Mail the original signed form (top copy) in the enclosed postage-paid envelope to:
   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400
5. Keep the bottom copy for your own records. If required, submit the middle copy to your employer group, union or trust fund.

- We'll review your form for completeness and required signatures. We'll then contact you by mail to let you know that we have received your form.
- 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.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Top white copy – Original signed copy – Kaiser Permanente
Middle yellow copy – Employer group/union/trust fund
Bottom white copy – Keep for your records

Employer Group Use Only
Optional Group Stamp Area:

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

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

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information:

Employer or Union Name:			Group #:
LAST Name: FIRST Name: Middle Initial:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )
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:			

Please Provide Your Medicare Insurance Information

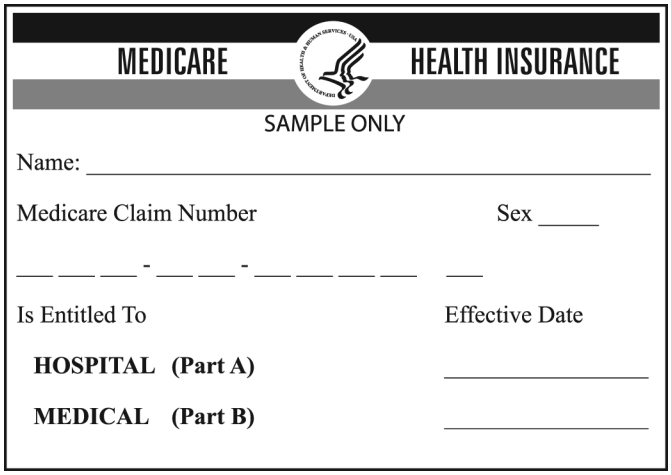
Please take out your Medicare card to complete this section.

- 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 Social Security or the Railroad Retirement Board.

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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:
   _____ _____

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 & phone number of institution (number and street): _____
   _____

7. Requested effective date (subject to CMS approval): _____/_____/_____

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

☐ Spanish

☐ Large Print ☐ Braille ☐ CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

Last Name _____ First Name _____

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 Senior 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): _____

Please Read and Sign Below

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, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

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 Part B, however some employer groups require both 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 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 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 Senior 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

Last Name _____ First Name _____

Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior 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 Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Kaiser Permanente and other services contained in my 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**.

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.

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: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____