Health Benefits Plan Enrollment for Retirees

888 CalPERS (or **888**-225-7377) • TTY (877) 249-7442 • Fax (800) 959-6545

For Retirees only. (Active employees - contact your Personnel Office).
To save time, complete this form before you request changes over the phone.

Section 1 — Type of Change

Check the type of change you are making.

- ☐ Change My Health Plan
- ☐ Enroll in a Health Plan
- ☐ Add Eligible Dependents to My Health Plan
- ☐ Open Enrollment (Check this box if the requested change is due to Open Enrollment)

You can make changes by calling **888 CalPERS** (or **888**-225-7377), by faxing this form to us at (800) 959-6545, or by visiting my|CalPERS at **my.calpers.ca.gov**.

Section 2 — Retiree Information

Be sure to include the name of the agency from which you retired.

If you are enrolled in Medicare, please send a copy of your Medicare card.

Name (First Name, Middle Initial, Last Name) | Social Security Number (- -)

Birthdate (mm/dd/yyyy) | Gender | Daytime Phone ( ) | Evening Phone ( )

Address | County (residence)

City | State | Zip

Retirement Date (mm/dd/yyyy) | Name of Former Employer

Section 3 — Health Plan

Before requesting a plan change, verify that the doctor you want is contracted with the health plan and is accepting new patients. If not, you will need to find another doctor who contracts with the new plan

Name of New Health Plan | Name of Doctor/Medical Group (include ID #s, if known)

Section 4 — Dependent Information

All dependents currently enrolled on your health plan will remain on your plan.

List only the dependents you are adding. If you have more than 3 dependents, please include on a separate page.

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Dependent Name | Social Security Number (- -) | Birthdate (mm/dd/yyyy)

Relationship | Gender | Doctor or Medical Group

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5 Retiree Signature

Please be sure to sign this form.

By signing this form, I elect to change the plan indicated above and/or add eligible family members. I also certify that the health information listed above is true and complete and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the health plan premium.

Signature of Retiree | Date

Section 6 Additional Information

You can submit your health plan changes by mail, by phone, or by fax.

After making changes to your health plan, be sure to examine your retirement check to verify that the proper deduction was made. If the deduction is incorrect, call CalPERS to report the discrepancy.

Health Benefits Plan Enrollment for Retirees

Use this form to enroll in a health plan, change your plan, or add an eligible dependent(s) to your plan if you meet all of the following requirements:

- Are eligible for enrollment on the date of separation
- Retired within 120 days from the day you separated from your job
- Are receiving a retirement check

Contact CalPERS with any eligibility questions.

Notes

- Any health plan changes made during Open Enrollment become effective the following January 1.
- You can use this form to make changes to your health plan outside of Open Enrollment due to a qualifying event, such as adding a new spouse, registered domestic partner, or dependent child.
  - Adding a spouse requires a copy of your marriage license
  - Adding a registered domestic partner requires a copy of the approved *Declaration of Domestic Partnership*
  - Adding a dependent child you have assumed a "parent-child relationship" with, requires an ***Affidavit of Parent Child Relationship***
- Be sure to report changes to CalPERS in a timely manner to avoid retroactive reimbursement liability.
- If you are enrolled in a Medicare Managed Care plan (Medicare Advantage) and are switching to a Supplement to Medicare plan, you must contact your current health plan or the nearest Social Security Administration office to disenroll your Medicare benefits from you current Medicare Managed Care plan. If you do not disenroll, Medicare will not pay for services you receive under your new health plan.
- If any one of your dependents is enrolled in Medicare, please send a copy of the Medicare card.

Mail to: California Public Employees' Retirement System P.O. Box 942715, Sacramento, CA 94229-2715

P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) |Fax (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

Certification of Medicare Status

Please complete **Section 1**, and either **Section 2, 3** or **4.** Sign and date the form and return it to CalPERS at P.O. Box 942715, Sacramento, CA 94229-2715.

Section 1: Please enter the Member's/Dependent's name and CalPERS ID.

CalPERS Retiree Name:	**CalPERS Retiree CalPERS ID:**
Medicare-Eligible Member/Dependent:	**Member/Dependent CalPERS ID:**

Section 2: For Member/Dependent Enrolled in Medicare Part A and B

☐ I am enrolled in Medicare Part A and Medicare Part B. This is the information reflected on my red, white and blue Medicare card or Notice of Entitlement from the Social Security Administration:

Name of Medicare Beneficiary:

Medicare Claim Number: _____

HOSPITAL (PART A) effective date: _____

MEDICAL (Part B) effective date: _____

Section 3: For Member/Dependent claiming Medicare Ineligibility

☐ I am not eligible for premium-free Medicare Part A (in my own right or through the work history of a current, former or deceased spouse). I have verified this with the Social Security Administration and have attached documentation of this fact.

Section 4: For Member/Dependent who works and has Employer Group Health Plan Coverage

☐ I have deferred Medicare Part B enrollment due to working beyond age 65 and have coverage in my/ my spouse's Employer's Group Health Plan and have attached documentation of this fact.

1. Name of your current employer
2. Name of your Group Health Plan provided by your employer

_____

Section 5: Member/Dependent Signature

I certify that the above information is true and correct.

_____ _____

Signature Date (mmddyyyy)

_____

Daytime telephone number

Revised 08/13

Kaiser Permanente Senior Advantage (HMO)

GROUP ELECTION REQUEST FORM

KAISER PERMANENTE®

Northern California or Southern California Region

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'll each need to complete a separate form. For help completing this form, call **1-800-443-0815**, toll free (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B, however some employer groups require both Parts A and B. You must live inside our Senior Advantage service area to enroll. Please check your enrollment materials to be sure you qualify for enrollment.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- Fill out the form completely then mail the top, original signed form in the enclosed postage-paid envelope to:
  Kaiser Permanente – Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400
- Keep the bottom copy for your own records. If required, also send a copy to your employer group or union/trust fund.
- We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
- 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.

SKU 60078689 (10/2011)

Top white original signed copy – Kaiser Permanente
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

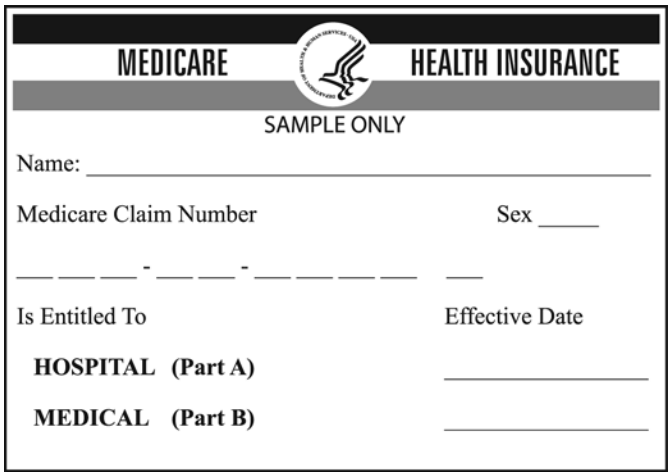
Please take out your Medicare card to complete this section.

- 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. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (month/date/year) _____
   If no, name of retiree _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse _____
   Name of dependents _____
3. Do you or your spouse work? ☐ Yes ☐ No
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 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.
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 this coverage.
   Name of other coverage ID # for this 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 for us to send you information in a language other than English or in another format:

☐ Spanish

This information is available for free in other languages. Please contact Member Services at **1-800-443-0815** (TTY **1-800-777-1370**) for additional information (seven days a week, 8 a.m. to 8 p.m.).

Se puede obtener esta información gratis en otros idiomas. Si desea información adicional, por favor llame a Servicios a los Miembros al **1-800-443-0815** (TTY **1-800-777-1370**) (los siete días de la semana, de 8 a.m. a 8 p.m.).

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 (29 CFR 2560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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 trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or 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 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 get it 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.

Last Name _____ First Name _____

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**.

If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

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 is 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 _____

Kaiser Permanente Senior Advantage (HMO), Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan (HMO SNP)

KAISER PERMANENTE®

DISENROLLMENT FORM

Northern California or Southern California Region

Each individual disenrolling will need to complete his/her own form. If you have any questions, please call us toll free at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing/speech impaired), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network. We will notify you of your effective date of disenrollment in writing after we get this form from you.

When enrolled in the Kaiser Permanente Senior Advantage plan, you can only disenroll at certain times during the year unless you meet certain special circumstances. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK			
KAISER PERMANENTE MEDICAL RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX: ☐ M ☐ F	HOME PHONE NUMBER	

PLEASE SELECT A DISENROLLMENT REASON BELOW

☐ I have moved out of the Kaiser Permanente service area

☐ I have joined another health plan

☐ My employer group coverage has ended

☐ Other—Please explain _____

Please carefully read and complete the following information before signing and dating this disenrollment form.

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

For Kaiser Permanente Medicare Cost plan members only: If you want to return to Original Medicare (also known as the Medicare fee-for-service program), then you must complete this disenrollment form. We will notify you of the effective date of your disenrollment after we have received this form from you.

WHITE—Kaiser Permanente
PINK—Employer group/union/trust fund
YELLOW—Keep for your records

Y0043_N004869 CMS Approved (05/16/2011)
SKU 60050607 CA

If you want to join another HMO immediately following termination from Kaiser Permanente Medicare Cost, then you do **not** need to complete this form. Once you enroll in another HMO, your current membership in Kaiser Permanente Medicare Cost will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year. I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

Disenrollment from the Kaiser Permanente Medicare Cost plan will be effective on the first day of the month after the month Kaiser Permanente receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to Kaiser Permanente on April 30, the last day of the month, your disenrollment will be effective the next day, May 1. If you are requesting a later date, disenrollment cannot take place later than the third month after which you submit a completed disenrollment request to Kaiser Permanente. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Senior Advantage or Medicare Cost may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior Advantage or Medicare Cost for Federal employees.

Your signature* _____ **Date** _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: (1) this person is authorized under State law to complete this disenrollment; and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

If you are the authorized representative, you must provide the following information:

Name _____

Address _____

Phone number _____

Relationship to enrollee _____

Kaiser Permanente is a health plan with a Medicare contract.

This information is available in a different format by calling the number listed on the first page.

Return the top, signed white copy to:

Kaiser Permanente—Medicare Unit
P.O. Box 232400
San Diego, CA 92193

If required, send the middle pink copy to your employer group or union/trust fund.
Keep the bottom yellow copy for your records.