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

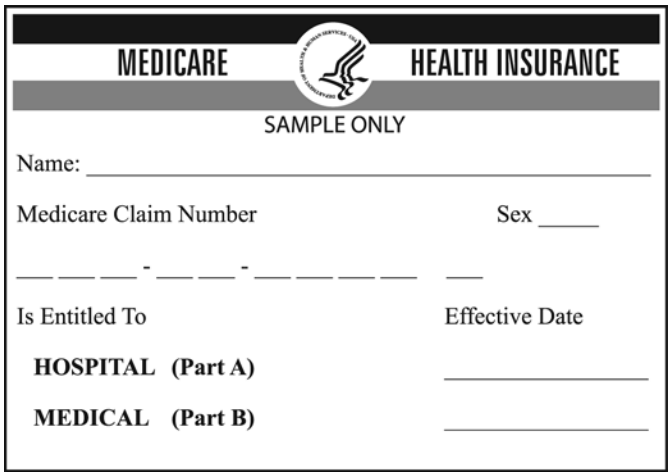
Please take out your Medicare card to complete this section.

- 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 _____