PLAN USE ONLY Representative ____________________

Election type: ☐ ICEP ☐ AEP ☐ OEP ☐ OEPNEW ☐ SEP ☐ IEP

TYPE OF COVERAGE YOU ARE APPLYING FOR, PLEASE CHOOSE ONE

Individual with Part D—Please note you cannot enroll in Kaiser Permanente Individual Senior Advantage or Senior Advantage II if you have Kaiser Permanente employer group Senior Advantage coverage.

☐ Individual Senior Advantage

☐ Individual Senior Advantage II

Proposed Senior Advantage effective date

____________________ (MM/DD/YYYY)

Employer group with Part D coverage—Your employer group has Medicare Part D, a prescription drug benefit.

☐ Group Senior Advantage

Employer group name ____________________

Employer group number ____________________

Proposed Senior Advantage effective date

____________________ (MM/DD/YYYY)

PLEASE COMPLETE THE INFORMATION BELOW

Last name | First name | MI | M F

Permanent residence street address (street address only—no P.O. box) | Apt. number

County | City | State | ZIP

Mailing address (if different from permanent residence address—P.O. box accepted) | Apt. number

County | City | State | ZIP

Daytime phone | Evening phone | Date of birth (MM/DD/YYYY)

Social Security number (SSN) | E-mail address (providing this information is optional)

Other contact: Name (providing this information is optional) | Phone number

ETHNICITY INFORMATION*

Optional: How would you describe yourself?

☐ American Indian or Alaskan native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Multi-ethnic
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other (please specify) ____________________

Optional: Do you need an interpreter? ☐ Yes ☐ No

Preferred language?

☐ Cantonese
☐ Korean
☐ Mandarin
☐ Russian
☐ Other (please specify) ____________________
☐ Sign language
☐ Spanish
☐ Vietnamese

* Stating your ethnicity and language is optional. This information can help Kaiser Permanente meet the health care needs of our members. It will be kept confidential.

White copy—Kaiser Permanente Yellow copy—Employer Pink copy—Applicant

Last name First name SSN

ADDITIONAL INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No

   If yes, please provide your current/former Kaiser Permanente health record number ________

2. Have you recently moved into our service area? ☐ Yes ☐ No Date of move ________

3. A) Do you have end-stage renal (kidney) disease? ☐ Yes ☐ No

   If you no longer need regular dialysis or have had a successful kidney transplant, please attach a note or records from your doctor showing this.

   B) If yes, transplant date ________

4. Are you currently living in a nursing care facility? ☐ Yes ☐ No If yes, admission date ________

   Facility name ________ Phone ________

   Address ________ City ________ State ________ ZIP ________

5. Are you covered by Medicaid (state-assisted health care benefits)? ☐ Yes ☐ No

   If yes, Medicaid # ________

6. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits Plan, VA benefits, or state pharmaceutical assistance programs.

   Will you have prescription drug coverage in addition to Kaiser Permanente Senior Advantage? ☐ 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 ________ Group # for this coverage ________

7. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage since you became eligible to join a Medicare drug plan? ☐ Yes ☐ No

   If no, you may have to pay a penalty. Kaiser Permanente may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call our Medicare Membership Services department at 1-877-221-8221, 7 days a week from 8 a.m. to 8 p.m. (TTY 1-800-735-2900).

EMPLOYER GROUP SENIOR ADVANTAGE APPLICANTS ONLY

1. Are you or your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you and/or your spouse? ☐ Yes ☐ No

   If yes, please provide the following information about the employer:

   Employer group name ________ Employer group # ________

   Insurance carrier policy # ________

2. A) Are you the retiree? ☐ Yes ☐ No If yes, retirement date ________

   If no, name of retiree ________

   B) Are you covering a spouse or dependents under this employer plan? ☐ Yes ☐ No

   If yes, name of spouse ________ Dependents ________

Last name First name SSN

INDIVIDUAL SENIOR ADVANTAGE APPLICANTS ONLY (Group members may not enroll in individual Senior Advantage or Senior Advantage II without losing their group coverage.)

You can have the monthly premium for Senior Advantage or Senior Advantage II automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail, by electronic funds transfer (EFT), or by credit card. Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like to pay the monthly premium for this plan directly to Kaiser Permanente? ☐ Yes ☐ No

If you check no, we will contact you about having your premiums automatically deducted from your Social Security check.

MEDICARE HEALTH INSURANCE CARD INFORMATION

Please complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Please copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare card or a copy of your Medicare verification letter that provides the same information.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

☐ PART A (HOSPITAL) ______________

☐ PART B (MEDICAL) ______________

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. 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 behalf of the individual, on this application certifies that I have read, understand, and agree to the contents of this application. I hereby apply for Kaiser Permanente Senior Advantage membership.

Applicant signature ______________________________ Date ______________

Power of attorney: 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 or by Medicare.

Authorized representative name ______________________________

Address ______________ Phone number ______________ Relationship to enrollee ______________

Anyone helping the applicant complete and sign this application is required to sign here:

Person assisting with form ______________________________ Date ______________

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

Application for membership
Individual Senior Advantage
Individual Senior Advantage II
Employer Group with Part D Plan

Important notice about this application for membership

Please read all pages before completing and signing this application. You must reside in our Kaiser Permanente service area and have both Medicare Part A and Part B to apply.

Questions?

For assistance completing this application, please call our Medicare Sales Department at 1-877-313-3424, Monday through Friday, 8:30 a.m. to 5 p.m. For TTY, call 1-800-735-2900. For language interpretation services in all areas, please call 1-800-324-8010. You may also contact our Medicare Membership Services department at 1-877-221-8221, seven days a week from 8 a.m. to 8 p.m.

Plan information

Completing and returning this application form is your first step to becoming a Kaiser Permanente Senior Advantage member.

- Please determine which plan you would like to apply for.
- Complete one application per person.

Medical information

- Complete the questions about end-stage renal disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life.
- Your application cannot be processed if this question is not answered.

Personal information

- Review the ZIP code service area section in our *Guide to Senior Advantage* to ensure that you live within the correct Kaiser Permanente Senior Advantage service area. Please note: Our Senior Advantage II plan is not available in the Longview, Wash., area (see plan *Summary of Benefits* for complete Senior Advantage II ZIP code area).
- Complete the personal information section. Be sure that you list your name **exactly** as it appears on your Medicare card.
- If possible please supply a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board. Remember you **must** have Medicare Part A and Part B to qualify for Senior Advantage coverage.

Signature

- On page 3—Don't forget to sign and date your application. [Use a ballpoint pen and press hard.]
- If someone has assisted you in completing this application, you both must sign and date the form and indicate your relationship.

Submitting the application

- Please keep the pink copy and return the original and yellow copy (you may also wish to give this copy to your employer) in the enclosed postage paid envelope to:

  Senior Advantage Medicare Sales Department
  Kaiser Permanente
  P.O. Box 5725
  Portland, OR 97228-9901

- Medicare is notified that you have applied to join Kaiser Permanente Senior Advantage.
- Within seven days after Medicare confirms your eligibility, we will confirm the effective date of your coverage.
- You will receive a new Kaiser Permanente ID card and information for new members.

Important: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please read this important information

If you currently have health coverage from an employer or union, joining Kaiser Permanente Senior Advantage could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Kaiser Permanente Senior Advantage may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can assist you.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

Application for membership
Individual Senior Advantage
Individual Senior Advantage II
Employer Group with Part D Plan

Important things to understand before signing this application

1. I will abide by Health Plan policies and rules that apply to me.
2. I understand that I cannot belong to another Medicare Advantage plan and Kaiser Permanente Senior Advantage at the same time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan in which I am currently a member.
3. I understand that I can be a member of only one Medicare Advantage plan at a time. I cannot enroll in more than one Medicare Advantage plan with the same effective date. If I do so, the enrollment form with the latest signature date will be processed by the Centers for Medicare & Medicaid Services (CMS).
4. I understand that I must maintain my enrollment in Medicare Part A and Part B insurance. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Kaiser Permanente or the Railroad Retirement Board (if a Railroad annuitant); or by calling Medicare 24 hours/7 days a week at 1-800-MEDICARE. TTY users should call 1-877-486-2048.
5. I understand that I will be notified by mail of the effective date of my Senior Advantage coverage. The effective date of my coverage will be determined by the date Health Plan receives my completed Senior Advantage election form. I also understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare Select plan until I receive confirmation from the Medicare Advantage plan.
6. I understand that I must reside in the Kaiser Permanente Senior Advantage service area. It is my obligation to notify Kaiser Permanente if I permanently move or leave the service area and that my absence means that Kaiser Permanente may take action to disenroll me.
7. I understand I may disenroll from Senior Advantage membership by submitting a written request to Kaiser Permanente or the Railroad Retirement Board (if a Railroad annuitant); or by calling Medicare 24 hours/7 days a week at 1-800-MEDICARE. TTY users should call 1-877-486-2048.
8. I understand I must receive all of my medical care from Kaiser Permanente from the effective date of my coverage, except for emergency or urgently needed care or out-of-area dialysis services. Also, any services received under the travel benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente. Neither Medicare nor Kaiser Permanente will pay for unauthorized doctor or hospital care received from non–Kaiser Permanente physicians or facilities. (Please refer to your *Evidence of Coverage* for full disclosure of benefits and the rules to follow for coverage under this plan).
9. I understand that as a member of the Kaiser Permanente Senior Advantage Plan, I have the right to appeal service and payment denials made by the Health Plan.