



ENROLLMENT FORM

Northwest Region Individual and Group Plan

IMPORTANT INFO – Read all pages before signing this form

Complete and return this form to become a Kaiser Permanente Senior Advantage (HMO) member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-877-221-8221** (TTY **1-800-735-2900**), seven days a week, 8 a.m. to 8 p.m. You may also contact our Medicare Marketing department at **1-866-523-6056** (TTY **1-800-735-2900**), weekdays, 8 a.m. to 5 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this enrollment 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 entitled to Medicare Part A and enrolled in Medicare Part B. You must live inside our Senior Advantage service area to enroll. Check the ZIP codes/counties listed in our *Summary of Benefits* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of

Senior Advantage unless one of the following is also true:

- You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Northwest region, and you are enrolling during an allowable enrollment period. To be eligible, there must be no break in coverage between your current Kaiser Permanente coverage and the start of your coverage in our Senior Advantage plan.
- You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
- You've had a successful kidney transplant and you attach a note or records from your doctor showing that you've had a kidney transplant and no longer need regular dialysis.
- You belong to an employer group or union/trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- After completing pages 1–4, read the sections titled "Release of Information" and "Conditions of Enrollment" at the end of this form. Then sign and date page 4.
- Keep the bottom white copy of this form. If required, send the middle yellow copy to your employer group or union/trust fund. Return the top, signed white copy in the enclosed postage-paid envelope to:
- 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.

Kaiser Permanente – Medicare Unit
P.O. Box 232407
San Diego, CA 92193-9914

CONDITIONS OF ENROLLMENT – By completing this form, I agree to the following:

1. I will read the Senior Advantage *Evidence of Coverage (EOC)* to know which rules I must follow in order to receive coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente at **1-877-221-8221 (TTY 1-800-735-2900)**, seven days a week, 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente is a health plan with a Medicare contract.
3. I must maintain my enrollment in Medicare Part A and Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. 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.
6. It's my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not 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.
8. I understand that I must enroll in the Senior Advantage service area in which I reside. I understand that it's my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than six months in a row.
9. **For Individual Plan Applicants ONLY:** Enrollment in this plan is generally for the entire year.
10. **For Individual Plan Applicants ONLY:** Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: between November 15 – December 31 for 2010), or under certain special circumstances, 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.
11. **For Employer Group/Union/Trust Fund Applicants ONLY:** 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.
12. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. Also, any services received under the Travel Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Senior Advantage *EOC* for more information about covered benefits and services. 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. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente 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.**
13. Once I become a member of Senior Advantage, I have the right to appeal plan decisions about payment/services.
14. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be compensated based on my enrollment in Kaiser Permanente.
15. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

For Employer Group/Union/Trust Fund Applicants ONLY: If you currently have health coverage from an employer or union/trust fund, joining Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Advantage. Read the communications your employer or union/trust fund sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any info on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form.

COMPLETE THE REQUIRED FIELDS BELOW


Last Name	First Name	Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt #
County	City	State	ZIP
Mailing address (if different from permanent residence)			Apt #
County	City	State	ZIP
Daytime phone number	Evening phone number		Date of Birth
Providing the following information is optional:			
E-mail address			
Other contact: Name		Phone number	

MEDICARE HEALTH INSURANCE CARD (REQUIRED INFO)

Complete this sample Medicare Health Insurance card with the information found on your own Medicare card. 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.

You must have Medicare Part A and Part 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)			_____	

For Individual Plan Applicants ONLY

PAYING YOUR PLAN PREMIUM

As a Senior Advantage Individual Plan member (not covered through an employer or trust fund), you can choose to pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) directly to our Plan, or you can have the monthly premium for this Medicare plan automatically deducted from your Social Security benefit check. If it is determined that you have a late enrollment penalty, you may also choose to have this deducted from your Social Security benefit check.

Select a premium payment option (if you don't make a selection, Kaiser Permanente will bill you directly):

- Kaiser Permanente to bill you directly for your premium.
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) **Note:** We don't recommend Social Security deduction if you're receiving extra help for your monthly plan premium payment from another payer. Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process.

Last Name: _____ First Name: _____

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for extra help online at socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, we will bill you for the amount of your premium that Medicare does not cover. You must continue to pay your Part B premium.

ADDITIONAL REQUIRED INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? Yes No
 If yes: Current Former Kaiser Permanente Health Record Number _____

2. Do you currently have end-stage renal (kidney) disease? Yes No
 If yes, provide: Diagnosis date (mm/dd/yyyy) ____ / ____ / ____
 Transplant date ____ / ____ / ____

See the section titled "Important info" on the cover page for more information about enrolling with ESRD.

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If yes, provide: Date of admission ____ / ____ / ____

Name of institution _____ Phone _____
 Address _____ City _____ State _____ ZIP _____

4. Are you enrolled in your State Medicaid program (state-subsidized medical plan)? Yes No
 If yes, provide Medicaid number _____

5a. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? Yes No
 If no, are you retired? Yes Retirement date ____ / ____ / ____

5b. Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? Yes No
 If yes, provide name of spouse's employer _____

6. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Senior Advantage? Yes No

If yes, list other coverage and ID number(s) for this coverage:
 Name of other coverage _____
 ID# for this coverage _____ Group # for this coverage _____

Last Name: _____ First Name: _____

For Individual Plan Applicants ONLY

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period (between November 15 and December 31 for 2010). There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Read the statements below and check the box for the statement(s) that apply to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you're eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled. We'll contact you if we need more information.

REQUIRED INFO

- I am new to Medicare.
- I recently moved outside of the service area of my current plan or I recently moved and this plan is a new option for me. Date of move ___/___/____
Previous address _____
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. Date I stopped receiving extra help ___/___/____
- I belong to a pharmacy-assistance program provided by my state.
- I live in or recently moved out of a long-term care facility (such as a nursing home).
Date of move ___/___/____
- I recently left a PACE program. Date I left program ___/___/____
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
Date I lost my drug coverage ___/___/____
- I am either losing coverage I had from an employer or union/trust fund or leaving employer or union/trust fund coverage.
Employer name _____
Employer group coverage termination date ___/___/____
- I recently returned to the United States after living permanently outside of the U.S.
Date of move ___/___/____
Previous address _____
- My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- None of these statements apply to me. (If none apply or if you're not sure, call us at **1-866-523-6056** (TTY **1-800-735-2900**), Monday through Friday, 8 a.m. to 5 p.m., to see if you're eligible to enroll. You may also contact our Medicare Membership Services Department at **1-877-221-8221**, seven days a week, 8 a.m. to 8 p.m.)

Last Name: _____ First Name: _____

For Individual Plan Applicants ONLY

TYPE OF COVERAGE YOU'RE APPLYING FOR (REQUIRED INFO)

Requested effective date (subject to CMS approval) ____ / ____ / ____

Individual Plan coverage

Select a specific plan: Senior Advantage Basic Senior Advantage

Would you also like optional supplemental benefits (i.e., Advantage Plus)?

Yes; additional premium \$ _____ No

You can't enroll in the Senior Advantage Individual Plans or Advantage Plus if you have employer group Senior Advantage coverage.

For Employer Group/Union/Trust Fund Applicants ONLY (REQUIRED INFO)

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID# _____ Subgroup _____

Requested effective date (subject to CMS approval) ____ / ____ / ____

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 any 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.

READ "CONDITIONS OF ENROLLMENT" BEFORE SIGNING AND DATING BELOW (REQUIRED INFO)

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 enrollment form means that I have read and understand the contents of this enrollment form. 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.

Signature of applicant or signature of authorized representative _____ Date ____ / ____ / ____

Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

Signature of any person who assisted in completing this form _____ Date ____ / ____ / ____

INTERNAL USE ONLY

Rep _____

IEP ICEP AEP SEP



Last Name: _____



TYPE OF COVERAGE YOU'RE APPLYING FOR (REQUIRED INFO)

Request the two lines (subject to CMS approval) _____

Individual (no coverage)

Self or spouse or a former Advantage Plan (Former Advantage)

VA (if you are the applicant) (Veterans Advantage Plan)

Family (individual or family) _____

You may want a former Advantage Plan or Advantage Plan if you have employer group coverage

Advantage coverage



If you currently have Kaiser Permanente coverage through more than one employer or with a third party, you must choose a coverage option for your Kaiser Advantage Plan and complete the information below

Priority Group (check the box that applies) _____

Priority Group (check the box that applies) _____

Request the two lines (subject to CMS approval) _____

RELEASE OF INFORMATION

By joining the Medicare health plan, I understand that the Medicare health plan will release my information to Medicare and other parties as necessary for cost payment and health care operations. I also

understand that Kaiser Permanente will release my information, including any personally identifiable information, to Medicare and other parties as necessary for cost payment and health care operations.

I understand that Kaiser Permanente will release my information, including any personally identifiable information, to Medicare and other parties as necessary for cost payment and health care operations.

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READ THE ENTIRE OR UNWARRANTED BEFORE SIGNING AND DURING BELOW (REQUIRED INFO)

I understand the my signing (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this enrollment form means that I understand and

understand that Kaiser Permanente will release my information, including any personally identifiable information, to Medicare and other parties as necessary for cost payment and health care operations.

I understand that Kaiser Permanente will release my information, including any personally identifiable information, to Medicare and other parties as necessary for cost payment and health care operations.

INTERNAL USE ONLY