



KAISER PERMANENTE

MEDICARE OUT-OF-AREA PROGRAM

You may be eligible for this program if you:

- have Medicare Parts A & B.
- permanently live or are moving outside the Kaiser Permanente Service Area.
- are currently a Kaiser Permanente employer group member and your employer group offers this program.
- have not currently assigned your Medicare benefits to another health plan.

If you meet the above requirements and would like to transfer your current Kaiser Permanente coverage to our Kaiser Permanente Medicare Out-of-Area Program, complete the following information and return it to your group benefits administrator.

ENROLL THE FOLLOWING PEOPLE

Name, Address and Phone Number	Medicare Claim #	Birth Date Mo/Day/Yr	Medical Record #	Medicare A Effective Date	Medicare B Effective Date
Subscriber: _____ Address: _____ Phone #: _____ Social Security #: _____					
Spouse: _____ Address: _____ Phone #: _____ Social Security #: _____					

Note: Currently enrolled non-Medicare dependents remain on the account but at non-Medicare rates and benefits.

MEDICARE ASSIGNMENT OF BENEFITS AND RELEASE INFORMATION

I request that payment of authorized Medicare benefits be made on my and/or my Medicare-eligible spouse's behalf to Kaiser Permanente for any services furnished to me and/or my spouse by Kaiser Permanente. I authorize any holder of medical information about me and/or my spouse to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine payable benefits.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim for myself and/or my spouse. If other health insurance coverage is indicated in Item 9 of the CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to Kaiser Permanente. In Medicare-assigned cases, Kaiser Permanente agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for non-covered services.

FOR CURRENT KAISER PERMANENTE SENIOR ADVANTAGE MEMBERS ONLY

I also understand and agree that by signing this form:

- I will be disenrolled from Kaiser Permanente Senior Advantage
- Until the effective date of my disenrollment from Kaiser Permanente Senior Advantage, I must continue to use Kaiser Permanente Plan providers for all my medical care except for emergency services, urgently needed care received while outside the Service Area, and authorized referrals.

ARBITRATION

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We understand that except for Small Claims Court cases and claims subject to a Medicare appeals procedure, any claim asserted for alleged violation of any duty to a Member arising out of the Service Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to the Agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. We understand that Members enrolled under this Agreement thus give up their right to a court or jury trial and instead accept the use of binding arbitration.

Signature

Date

Spouse's Signature

Date

DISTRIBUTION: WHITE and CANARY = Return to your Employer Group's Benefits Administrator
(WHITE = Kaiser Permanente • CANARY = Employer • PINK = Retain for your Records)