KAISER PERMANENTE®

Individual Plan

Kaiser Permanente Medicare Advantage (HMO)

Enrollment form

Washington Region Individual Plan

Have you thought about enrolling on **wa-medicare.kaiserpermanente.org/enroll** instead? It's a fast, secure, and easy way to apply.

You can also talk with someone at our Medicare Sales Team who'll help you enroll over the phone: **1-877-588-5740** (calling this number will direct you to a licensed sales specialist) (TTY **711**), seven days a week, 8 a.m. to 8 p.m. For current members changing plans, call Member Services at **1-888-901-4600** (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign the form on page 6 and date it. **Make sure you've read all the pages before you sign.**
3. Make a copy for your records.
4. Mail the original, signed form to:

   Kaiser Permanente – Medicare Enrollment
   P.O. Box 34255
   Seattle, WA 98124-1255
5. Fax Number: 206-988-7543

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Medicare Advantage.
- Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send you a Kaiser Permanente ID card and information for new members.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. You must reside in the Kaiser Permanente Medicare health plan service area in which you enroll.

H5050_00009039 approved
343169123A WA 10/2019

Name

Kaiser Permanente Medical/Health Record Number (for current or past members)

Please contact Kaiser Permanente if you need information in another language or accessible format (Braille).

To enroll in Kaiser Permanente Medicare Advantage, please provide the following information

Please check which plan you want to enroll in (you must reside within a Kaiser Permanente service area):

King, Pierce, and Thurston counties:

- ☐ Kaiser Permanente Medicare Advantage Key (HMO) - $0 per month
- ☐ Kaiser Permanente Medicare Advantage Vital (HMO) - $28 per month
- ☐ Kaiser Permanente Medicare Advantage Essential (HMO) - $99 per month
- ☐ Kaiser Permanente Medicare Advantage Optimal (HMO) - $295 per month
- ☐ Kaiser Permanente Medicare Advantage Basic (HMO), No Part D - $40 per month

Kitsap, Lewis, Snohomish counties and partial counties Grays Harbor ZIP codes (98541, 98557, 98559, 98568) and Mason County ZIP codes (98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592):

- ☐ Kaiser Permanente Medicare Advantage Vital (HMO) - $28 per month
- ☐ Kaiser Permanente Medicare Advantage Essential (HMO) - $99 per month
- ☐ Kaiser Permanente Medicare Advantage Optimal (HMO) - $295 per month
- ☐ Kaiser Permanente Medicare Advantage Basic (HMO), No Part D - $40 per month

Spokane County:

- ☐ Kaiser Permanente Medicare Advantage Centennial (HMO) - $0 per month
- ☐ Kaiser Permanente Medicare Advantage Columbia (HMO) - $99 per month
- ☐ Kaiser Permanente Medicare Advantage Basic (HMO), No Part D - $40 per month

Island, Skagit, and Whatcom counties:

- ☐ Kaiser Permanente Medicare Advantage Harbor (HMO) - $85 per month
- ☐ Kaiser Permanente Medicare Advantage Basic (HMO), No Part D - $40 per month

Optional Dental plan (optional supplemental benefits package):
Would you also like to add Dental coverage to your Kaiser Permanente Medicare Advantage plan? The Optional Dental plan package is not required. For an additional $54 per month, you can add this benefit. The monthly premium for the Optional Dental plan will be added to your Medicare Advantage monthly premium. ☐ Yes ☐ No

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. This information is not a complete description of benefits. Call **1-888-901-4600** (TTY **711**) for more information.

Name

LAST Name:

☐ Mr. ☐ Mrs. ☐ Ms.

FIRST Name:

Middle Initial:

Sex:
☐ Male ☐ Female

Home Phone Number: - -

Mobile Phone Number: - -

Birth Date: (mm/dd/yyyy) / /

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 red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A) / /

MEDICAL (Part B) / /

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Kaiser Permanente the Part D-IRMAA.

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 **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

After you receive your first bill, you can choose a different payment option. If you want your monthly premium bill mailed to a different address than your other mail, please provide that address here:

City: County: State: ZIP Code:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Name

Please read and answer these important questions:

1. 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 anymore, **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.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, 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:

   Group # for this coverage:

3. 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 of Institution (number and street):

   Phone Number: - -

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If "yes," please provide your Medicaid number:

5. Do you or your spouse work? ☐ Yes ☐ No

Selecting a primary care provider: To select your primary care provider with Kaiser Foundation Health Plan of Washington (primary care providers do not include specialists), please include their name here. **Note:** If you are a current Kaiser Permanente member and are not making a primary care provider change, please leave blank.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Large Print ☐ Braille ☐ CD

Please contact Kaiser Permanente at **1-888-901-4600** if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **1-800-833-6388** or **711**.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Kaiser Permanente could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Kaiser Permanente Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Name

Please Read and Sign Below

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 Parts A and B. I can be in only 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 or prescription drug 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. Enrollment in this plan is generally for the entire year. 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: October 15 – December 7 of every year), or under certain special circumstances.

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 **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.

I understand that beginning on the date Kaiser Permanente Medicare 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 Kaiser Permanente **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.**

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.

Dental plan optional supplemental benefits conditions of enrollment

If you checked "Yes" to add the Dental optional supplemental benefits package on page 1, please read the information below.

By completing this enrollment application:

- I understand that the Dental plan optional supplemental benefits package is only available to members enrolled in a Kaiser Permanente Medicare Advantage Plan.
- I understand that I must get covered care from network providers, except for emergency or urgently needed services.
- I understand that I can stop my Dental plan optional supplemental benefits package coverage anytime. If I disenroll, I won't be eligible to enroll again until the next Dental plan optional supplemental benefits package annual election period for coverage that has a start date of January 1, 2021.

Name

Release of Information: By joining this Medicare health plan, I acknowledge that Kaiser Permanente 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, which may release it for research and other purposes that 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:

Agent Use Only:

Date Received by Agent: / / Released to Client for Submission: / /

☐ ICEP/IEP ☐ AEP ☐ Not Eligible Effective Date of Coverage: / /

☐ SEP (reason if SEP)

Appointment type Scope of Appointment attached ☐ Yes ☐ No

Name of Kaiser Permanente staff member

Broker or agent name

Kaiser Permanente agent ID number

Company/house name (if applicable)

Kaiser Permanente house ID number Phone number - -

Name

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently was released from incarceration. I was released on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently left a PACE program on (insert date) ☐☐/☐☐/☐☐☐☐.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ☐☐/☐☐/☐☐☐☐.

Name

- ☐ I am leaving employer or union coverage on (insert date) ☐☐ / ☐☐ / ☐☐☐☐.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ☐☐ / ☐☐ / ☐☐☐☐.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ☐☐ / ☐☐ / ☐☐☐☐.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Kaiser Permanente at **1-800-446-8882** (TTY users should call **1-800-833-6388** or **711**) to see if you are eligible to enroll. We are open seven days a week, from 8 a.m. to 8 p.m.

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ **(Khmer)**៖ របយ័ត៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរអក។ ចូរទូ រស័ព

1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (Japanese): 注意事項：日本語を話される場 合、無料の言語支援をご利用いただけます。 1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (**መስማት ለተሳናቸው**: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ **(Punjabi)** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (1-800-833-6388 / 711) .

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.

XB0001444-56-18