KAISER PERMANENTE®

VIRGINIA

Kaiser Foundation Health Plan of the
Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street, Rockville, Maryland 20852

KAISER PERMANENTE ENROLLMENT & CHANGE FORM
HMO PLAN OFFERINGS
INSTRUCTIONS

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). We look forward to receiving your Enrollment and Change form. If you have any question concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at **(800) 777-7902 TTY Services: (301)-879-6380** before signing this form.

After you have completed this form, please sign and return it to your employer's benefits office. DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.

If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.

How to Complete this form – Please Print

Use this form to enroll, waive or change (add or delete) your family members' membership status. To be a Subscriber, you must live or work within our service area and you must be an employee who meets all of your employer's eligibility guidelines. If you are electing to waive coverage, you only need to complete Sections A, B and sign in section G. If you have any questions, contact your employer's benefits office.

To Be Completed by Employer

Your employer will complete this section.

Section A: Employee Information

Please provide information about yourself. To indicate your choice of primary care provider, please see the line at the end of the section.

Section B: Waiver of Coverage

Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. You will also need to read and sign section G.

If Making a Change Section

Complete this section if you are making a change (add or delete) to dependent status. If you are adding a dependent please complete sections A, C, F and G.

Section C: Family Information

Make sure your dependents meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office. If you know the Medical record number, please provide it in the requested space. To select a primary care provider, please review the KFHP-MAS Provider Directory and enter the provider code of the primary care provider for you and each member of your family. The primary care provider must be listed in the KFHP-MAS portion of the Provider Directory. To obtain a directory please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380, or see our website at www.kp.org.

Section D: Maximum Age/Disabled Dependent

Please complete this section to list any dependents that exceed your employer's' maximum limiting age requirements or are disabled. You will be requested to provide additional information to document dependents that are indicated in this section.

Section E: Dependents residing at another PERMANENT address

Please use this section to document any dependents that have another permanent address other than that of the Subscriber. You will be requested to provide additional information to document dependents that are indicated in this section. This section does not apply to dependents who are full time students living in temporary housing while attending their classes.

Section F: Other Coverage Information	Section G: Subscriber Sign-off
Tell us if you, your spouse, or other family dependents are covered by other group health insurance plans. This may occur when both spouses are employed and have health care benefits from one or more health plan(s). If you or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans. If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners (NAIC) guidelines including , but not limited to; Medicare, Motor Vehicle Insurance (Except Virginia residents and Virginia group employees. Virginia residents and Virginia group employees are not subject to subrogation of a recovery for personal injuries from a third person.), Workers' Compensation, Tricare, Veterans Administration, so long as you are enrolled in the primary plan and such plan remains primary to KFHP – MAS plan. Your signature authorizes KFHP-MAS and its employees to release any records or information with respect to any claim for covered services that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380.	Review and sign this form. Before you sign this form, please make certain you have read all coverage materials and have selected a primary care provider. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card. MISREPRESENTATION If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties. You may also be liable to KFHP-MAS for the cost of health care services provided because of the false or misleading information or omission.

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM

*Additional documentation will be required.

†† May require additional information

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Please see instructions located at the back of this booklet for directions on how to complete this form. After you have completed this form, please sign and return all pages, including the instructions, to your employer's benefits office. DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.

If you are enrolling in our Medicare product, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.

TO BE COMPLETED BY EMPLOYER Please print or type in black ink only.

ENROLLMENT TYPE ☐ NEW ☐ CHANGE

EMPLOYMENT STATUS ☐ Active ☐ Retired

GROUP NO. ☐☐☐☐☐

SUBGROUP NO. ☐☐☐☐

THE INFORMATION BELOW IS REQUIRED BY LAW. FAILURE TO COMPLETE WILL RESULT IN A DELAY OF APPLICATION PROCESSING.

☐ CHECK IF NEW HIRE

IF NEW HIRE, INDICATE NEW HIRE DATE (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

EMPLOYEE LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐

MI ☐

SUFFIX ☐☐

Check One and indicate date of event:

☐ New enrollment — New enrollment Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

☐ Open enrollment (complete sections A, C, F, G) — Open enrollment Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

☐ COBRA (complete sections A, B, E, G) — COBRA Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

☐ Loss of other coverage (complete sections A, C, F, G)

☐ Cancel all coverage (empl. and family) (complete sections A, G) — Effective Date of Cancellation (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE

I hereby certify that this(these) enrollment(s) has been reviewed and meet(s) all eligibility requirements

Printed or Typed Name/Title		
Employer Signature		
Date	Telephone	Fax

*Additional documentation will be required.
†† May require additional information

A. EMPLOYEE INFORMATION

ENROLLMENT TYPE ☐ SELF ONLY ☐ SELF & DEPENDENTS complete sections A, C, F, G)

PLAN Check one:

☐ HMO Signature ☐ Select ☐

☐ Added Choice Signature ☐ Select ☐

☐ **Deductible HMO** (DHM) Signature ☐ Select ☐

☐ **Deductible HMO w/HRA** (DHR) Signature ☐ Select ☐

☐ **HSA-Qualified HMO** (HHM) Signature ☐ Select ☐

☐ **HSA-Qualified HMO w/HRA** (HHR) Signature ☐ Select ☐

COMPANY NAME

LAST NAME FIRST NAME MI SUFFIX

SOCIAL SECURITY NUMBER MEDICAL RECORD NO. DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE

ADDRESS

APARTMENT NUMBER CITY

STATE ZIP CODE HOME PHONE WORK PHONE

Email address (Optional)

Primary Care Provider (PCP) Name _____ PCP ID #

*Additional documentation will be required.
†† May require additional information

B. Waiver of Coverage

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

☐ All Coverage ☐ Coverage for my Spouse

☐ Coverage for my Children

I understand that if I or my Dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit documentation to support enrollment outside the Open Enrollment period and coverage may be subject to late enrollment provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all appropriate boxes)

☐ other group coverage sponsored by my employer*

☐ other group coverage sponsored by my Spouse's employer*

☐ other group coverage sponsored by another organization*

☐ other reasons (please explain)

_____

_____

_____

_____

_____

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

ADD DEPENDENTS (Complete sections A, C, F, G)

	Date of Event (MM/DD/YYYY)		Date of Event (MM/DD/YYYY)
☐ Birth††	☐☐☐☐☐☐☐☐	☐ Loss of other Coverage*	☐☐☐☐☐☐☐☐
☐ Adoption*	☐☐☐☐☐☐☐☐	☐ Marriage*	☐☐☐☐☐☐☐☐

☐ Address (complete sections A, G)

☐ Telephone (complete sections A, G)

☐ Name Change* _____

☐ Other (please specify; Complete sections A, C, G)*

Previous Name _____

C. FAMILY INFORMATION (If additional space is needed please use another form and attach it to this form)

☐ ADD ☐ DELETE ☐ SPOUSE ☐ DOMESTIC PARTNER (If eligible under your plan)

LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐ SUFFIX ☐☐☐

SOCIAL SECURITY NUMBER ☐☐☐☐☐☐☐☐☐

MEDICAL RECORD NO. ☐☐☐☐☐☐☐☐☐☐

DATE OF BIRTH (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

MALE ☐ FEMALE ☐

Primary Care Provider (PCP) Name _____ PCP ID # ☐☐☐☐☐☐

☐ ADD ☐ DELETE ☐ CHILD ☐ OTHER _____

LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐ SUFFIX ☐☐☐

SOCIAL SECURITY NUMBER ☐☐☐☐☐☐☐☐☐

MEDICAL RECORD NO. ☐☐☐☐☐☐☐☐☐☐

DATE OF BIRTH (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

MALE ☐ FEMALE ☐

Primary Care Provider (PCP) Name _____ PCP ID # ☐☐☐☐☐☐

*Additional documentation will be required.

†† May require additional information

C. FAMILY INFORMATION (Cont.)

☐ ADD ☐ DELETE ☐ CHILD ☐ OTHER _____

LAST NAME FIRST NAME MI SUFFIX

SOCIAL SECURITY NUMBER MEDICAL RECORD NO. DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE

Primary Care Provider (PCP) Name _____ PCP ID #

☐ ADD ☐ DELETE ☐ CHILD ☐ OTHER _____

LAST NAME FIRST NAME MI SUFFIX

SOCIAL SECURITY NUMBER MEDICAL RECORD NO. DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE

Primary Care Provider (PCP) Name _____ PCP ID #

D. Are any of your listed dependents over the Groups' maximum age(s)? If yes, please complete the following:

Name(s) (Last, First, MI)	Disabled*	Full-Time Student*	Name of College, University, or Trade School
	☐ YES ☐ NO	☐ YES ☐ NO	
	☐ YES ☐ NO	☐ YES ☐ NO	

E. Do any of your dependents above permanently reside at another address? ☐ YES** ☐ NO If yes, please complete the following:

Dependent Information:

LAST NAME FIRST NAME MI SUFFIX

ADDRESS

APARTMENT NUMBER CITY

STATE ZIP CODE

** If additional space is needed please use another form and attach it to this form

*Additional documentation will be required.

†† May require additional information

F. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? ☐ YES ☐ NO

Name	Insurance Carrier Name	Policy Number	Telephone Number

Are you or any of your dependents eligible for Medicare? ☐ YES ☐ NO

If Yes, please complete the following:

MEDICAID NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐

MEDICARE (HIC) NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐

☐ MEDICARE Part A Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

☐ MEDICARE Part B Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

☐ MEDICARE Part D Effective Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

G. Important: I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this form is accepted, coverage will be provided according to the terms and conditions of my employer's contract with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

I authorize KFHP-MAs and its employees to release any records or information with respect to any claim for covered services that may be requested by another insurance carrier. Such authorization shall be valid for the duration of coverage.

I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties may include imprisonment and/or fines. In addition, KFHP-MAS may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

Employee/Applicant Signature	Date	Employer Signature	Date

*Additional documentation will be required.

†† May require additional information