KAISER PERMANENTE®

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

☐ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

DC, MD, and VA MID/LARGE Employee Enrollment & Change Form

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) or Kaiser Permanente and Kaiser Permanente Insurance Company (KPIC). **If you have any questions concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at 1-800-777-7902 or TTY 711 for the deaf, hard of hearing, or speech impaired before signing this form.**

Please print. Use this form to enroll, waive, or change (add or delete) your family's membership status. To be a subscriber, you must live, work, or reside within our service area and you must be an employee who meets all of your employer's eligibility guidelines. **If you elect to waive coverage, you only need to complete Sections A and C.** If you have any questions, contact your employer's benefits office.

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 1-800-777-7902 or TTY 711 for the deaf, hard of hearing, or speech impaired for more information.

SECTION A: Applicant Information

Please provide information about yourself in the relevant sections.

SECTION B: Benefit Plan Requested

Please provide information for the plan that you are selecting.

SECTION C: Waiver of Coverage

Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. Read and sign section C.

SECTION D: Family Information

Dependent(s) must meet your group's eligibility guidelines. If you have any questions on coverage, contact your employer's benefits office.

SECTION E: Other Coverage

If you, your spouse or domestic/civil union partner++ or other family dependents 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 a COB provision applies to you, your signature on this form will permit KFHP-MAS/KPIC to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners and Workers' Compensation, so long as you are enrolled in the primary plan and such plan remains primary to KFHP-MAS/KPIC plan.

Maximum age/disabled dependent
Please complete this section to list any dependents who 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.

Dependents residing at another PERMANENT address
Please use this section to document any dependents who have a 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.

++Civil Union Partner - DC only

SECTION F: Subscriber Signature

Review and sign this form. Before doing so, please make certain you have read all coverage materials. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card. If you are voluntarily electing to waive all insurance coverage offered by your employer, please only complete section A and C.

SECTION G: Employer Authorized Representative

TO BE COMPLETED BY EMPLOYER.

KAISER PERMANENTE

Company Name:	Effective Date*:	Date of Qualifying Event:	Group Number:

☐ New Enrollment ☐ Self Only ☐ Self and Dependent(s) ☐ Open Enrollment ☐ New Hire	☐ Qualifying Life Event ☐ COBRA ☐ Rehire / Reinstatement ☐ Waiver ☐ Other _____	☐ Change of Coverage ☐ Add Spouse or Domestic/Civil Union Partner*** ☐ Add Dependent Child* ☐ Name Change* ☐ Other _____	☐ Employee Termination ☐ Remove Spouse or Domestic/Civil Union Partner*** ☐ Remove Dependent Child* ☐ Cancel Coverage

SECTION A: Applicant Information

Must be completed by the employee.

Employee Last Name: First Name: MI: Suffix:

Date of Birth: __/__/____ Male: ☐ Female: ☐

Address: Unit #:

City: State: ZIP Code:

Home Phone: Work Phone: Social Security Number: ___-___-____

Email Address:

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS or KPIC?

☐ Yes ☐ No

Check One:

☐ Full-Time ☐ Part-Time ☐ 1099 Contractor
☐ Seasonal ☐ Temporary ☐ Retiree

If you do not physically work at your employer's address, please provide your primary working address:

Enter only one group health plan as provided by your employer.

Medical Plan Selected: _____ **Service Delivery Options:**** ☐ Signature ☐ Select

Benefits underwritten by KFHP-MAS:
HMO, DHMO, HDHP, Added Choice POS, Option 1 of Flexible Choice, Option 1 of 2T Added Choice POS, KPMP (HMO, DHMO, HDHP), HMO Plus, DHMO Plus, Option 1 of Deductible Flexible Choice, Option 1 of HSA-Qualified Flexible Choice

Benefits underwritten by KPIC:
Option 2 (Out-of-Network) of Added Choice 2T POS, Option 2 (PPO) and Option 3 (Out-of-Network) of Flexible Choice, Option 2 (PPO) and Option 3 (Out-of-Network) of Deductible Flexible Choice, Option 2 (PPO) and Option 3 (Out-of-Network) of HSA-Qualified Flexible Choice, and Out-of-Area PPO

***Consult your employer for the effective date.**
***Additional information may be requested.**
**The Service Delivery Options only apply to the benefits underwritten by KFHP-MAS. They do not apply to the products underwritten by KPIC.
***Civil Union Partner - DC Only

KAISER PERMANENTE®

SECTION C: 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 or domestic/civil union partner**
- ☐ Coverage for my child(ren)

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:

- ☐ Other group coverage sponsored by my spouse's or domestic/civil union partner's** employer*
- ☐ Other group coverage sponsored by another organization*
- ☐ Medicare/Medicaid/TRICARE*
- ☐ Individual coverage*
- ☐ Parental coverage*
- ☐ Other reasons (please explain)

_____

_____

***Additional information may be requested.**
****Civil Union Partner - DC Only**

Waiving Employee Signature: _____ **Date:** _____

SECTION D: Family Information

Must be completed by employee.

If additional space is needed, please use another form and attach to this form.

Spouse or Domestic/Civil Union Partner** *(If eligible under your plan)*

Last Name: First Name: MI: Suffix:

Social Security Number: Date of Birth: Male: ☐ Female: ☐ Relationship to Employee:

Last Name: First Name: MI: Suffix:

Social Security Number: Date of Birth: Male: ☐ Female: ☐ Relationship to Employee:

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

Name(s) (Last, First, MI)	Disabled*	Reason
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Do any of your dependents above permanently reside at another address?

☐ Yes ☐ No

If yes, please complete the following. If additional space is needed, please use another form and attach to this form.

Last Name: First Name: MI: Suffix:

Address: Unit #:

City: State: ZIP Code:

***Additional information may be requested.**
****Civil Union Partner - DC Only**

KAISER PERMANENTE®

SECTION E: Other Coverage

Including yourself, do any of the persons listed below have other health coverage? ☐ Yes ☐ No

If yes, please list below.

Name	Insurance Carrier Name	Policy Number	Telephone Number

Are you or any of your dependents eligible for Medicare? ☐ Yes ☐ No

Your signature authorizes KFHP-MAS/KPIC 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. You may cancel your authorization by written request mailed to Kaiser Permanente, Release of Medical Information Service Center, 5th Floor, 6501 Loisdale Court, Springfield, VA 22150. Fax Number (855)-902-8624. Revocation will become effective on the date of receipt of your written revocation, except as follows:

i. **any actions that were taken by KFHP-MAS/KPIC in reliance on the authorization before receipt of the written revocation will not be affected by the revocation;**
ii. **revocation of an authorization that was used to obtain coverage, including coverage from KFHP-MAS/KPIC, will not be permitted during the period of time that KFHP-MAS/KPIC may contest the plan issued or a claim for services under the plan; and**
iii. **if a partial revocation is received by KFHP-MAS/KPIC, the use or disclosure of records or information not affected by the revocation may continue.**

Once disclosed, the information may be further disclosed to others and may no longer be protected under applicable privacy law. Your authorization is valid for the term of coverage of the policy unless you cancel it earlier. You will not be denied treatment, payment of claims, enrollment, or eligibility for benefits based on whether you sign this authorization. You or your authorized representative are entitled to receive a copy of the authorization form.

Employee / Applicant Signature: _____ **Date:** _____

SECTION F: Request for Enrollment or Cancellation*

☐ **Request for Enrollment**
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 KFHP-MAS/KPIC, I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay required subscription charges to my employer.

☐ **Request for Cancellation**
I hereby request on behalf of myself and each dependent listed above, that my coverage be cancelled.

☐ Remove spouse or domestic/civil union partner**

☐ Remove dependent child(ren) – Name(s): _____

☐ Cancel entire coverage

Employee / Applicant Signature: _____

*Consult your employer for the effective date.
**Civil Union Partner - DC Only

Enrollees from the following states are to refer to their specific state warning:

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime may be subject to confinement in prison.

Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this enrollment card. 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.

SECTION G: 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:** _____ **Phone Number:** _____

Employee Signature: _____ **Date:** _____