Kaiser Permanente Senior Advantage (HMO) or
Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan (HMO SNP)

INDIVIDUAL ENROLLMENT REQUEST FORM

Northern California or Southern California Region
Individual Plan

KAISER PERMANENTE®

IMPORTANT INFO – Read all pages before signing this form

Completing and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this form signifies that you've read, understand, and agree to these provisions.
- Kaiser Permanente is a health plan with a Medicare contract.
- The Kaiser Permanente Senior Advantage Medicare Medi-Cal plan is a Coordinated Care plan with a Medicare Advantage contract but without a contract with the state Medicaid program.
- 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. Please check your enrollment materials to be sure you qualify for enrollment.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- **If you are completing a paper form,** fill out the form completely and then mail the original signed form (top copy) in the enclosed postage-paid envelope. Keep the bottom copy for your own records.
- **If you downloaded this form online**, print out the form, fill out the form completely, and make a copy for your own records. Then mail the original signed form to
  Kaiser Permanente – Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400.
- We'll review your form for completeness and required signatures. We'll then contact you by mail to let you know that we have received your form.
- 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.

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

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information:

Please check which plan you want to enroll in:

Individual Plan coverage

☐ **Senior Advantage**
If you live in the Fresno, Kern, Kings, Madera, Mariposa, San Joaquin, Stanislaus, or Tulare County service area, select one of the following plan options: ☐ Enhanced ☐ Basic

☐ **Senior Advantage Medicare Medi-Cal Plan (HMO SNP)***
*A Medicare Advantage plan for people who are entitled to both Medicare and Medi-Cal benefits.

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	Home Phone Number ( )	Alternate Phone Number ( )

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No

If yes: ☐ Current ☐ Former Kaiser Permanente Medical/Health Record Number _____

Permanent Residence Street Address (P.O. Box is not allowed)

County	City	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

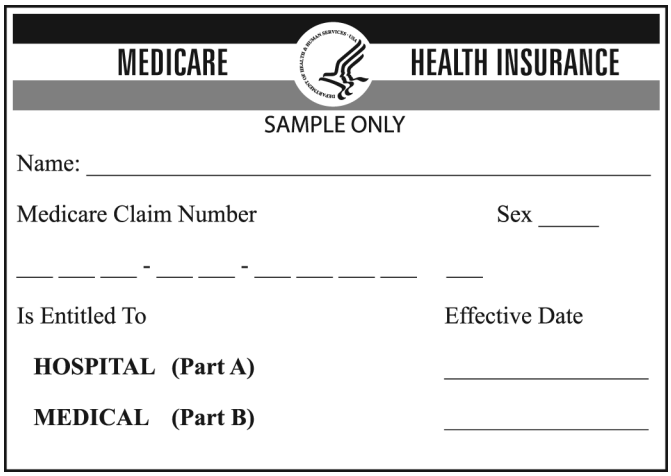
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

- OR -

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

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) _____

Last Name _____ First 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 or Railroad Retirement Board 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 monthly bill

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

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 any more, **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 & phone number of institution (number and street) _____

Last Name _____ First Name _____

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

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

☐ Spanish

☐ Chinese for residents of Alameda, Napa, or San Francisco counties

This information is available for free in other languages. Please contact Member Services at **1-800-443-0815** (TTY **1-800-777-1370**) for additional information (seven days a week, 8 a.m. to 8 p.m.).

Se puede obtener esta información gratis en otros idiomas. Si desea información adicional, por favor llame a Servicios a los Miembros al **1-800-443-0815** (TTY **1-800-777-1370**) (los siete días de la semana, de 8 a.m. a 8 p.m.).

此資訊免費以其他語言提供。要獲得詳細資訊，請聯絡 會員服務，電話號碼爲 **1-800-443-0815** (打字電話 **1-800-777-1370**)，(每週七天、早上8點至晚上8點)。

Please Read This Important Information

If you currently have health coverage from an employer or union, 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 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.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Kaiser Permanente Senior Advantage 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

Last Name _____ First Name _____

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 Senior 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 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.**

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.

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, 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.

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 _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment) _____

Plan ID # _____ Effective Date of Coverage _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____

Last Name _____ First 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(es) 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 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.

☐ 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) _____.

☐ 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 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) _____.

If none of these statements applies to you or you're not sure, please contact Kaiser Permanente at **1-800-443-0815** (TTY users should call **1-800-777-1370**) to see if you are eligible to enroll. We are open seven days a week, from 8 a.m. to 8 p.m.