KAISER PERMANENTE®

Group Plan

Kaiser Permanente Senior Advantage (HMO)

Group Medicare Election Form – California

Filling out 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 fill out a separate form. For help completing this form, call Kaiser Permanente at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

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 and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Southern California IBEW-NECA
   Admin Corp
   P.O. BOX 6652
   PASADENA, CA 91109

   You can also fax or email your completed form to:

   FAX: (323)726-3520

   EMAIL: retirementbenefits@scibew-neca.org
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

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 Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus**.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Employer Group Use Only
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

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

Employer or Union Name: _____ Group #: _____

LAST Name: _____

FIRST Name: _____ Middle Initial: ☐ Sex: ☐ Male ☐ Female

Primary Phone Number: _____ Secondary Phone Number: _____ Birth Date: (mm/dd/yyyy) _____

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 (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

_____

City: _____

County: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Last Name _____ First Name _____

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 B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

2. Are you the retiree? ☐ Yes ☐ No
   If "yes", retirement date (mm/dd/yyyy):
   If "no", name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If "yes", name of spouse:
   Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

5. 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:

Last Name First Name

6. Requested effective date of enrollment into this plan (subject to CMS approval):

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

Please complete the information below if you currently have Kaiser Permanente coverage through more than one employer or union/trust fund. You must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name:

Employer Group/Union/Trust Fund ID #: Subgroup:

Requested effective date of enrollment into this plan (subject to CMS approval):

Last Name _____ First Name _____

Please Read and Sign Below

KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT

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 Part B, however most employer groups require both Parts A and B. I can only be in 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. 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. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

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 Senior Advantage **Evidence of Coverage** document from Kaiser Permanente in order to know which rules I must follow to get coverage with this Medicare Advantage plan.

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.

Last Name | First Name

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as 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.

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Enrollee or Authorized Representative Signature:

Today's Date:

If you are the authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this enrollment request on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above and provide your information below:

Name:

Address:

Phone Number: **Relationship to Enrollee:**

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente - Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

Last Name | First Name

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Do not complete this section if you are the enrollee or their legal/authorized representative.

Name:

Relationship to Enrollee:

Signature:

National Producer Number (Agents/Brokers only):

Office Use Only:

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

Plan ID #: Effective Date of Coverage:

ICEP/IEP: OEP: SEP (type):