



KAISER PERMANENTE®

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

**KAISER PERMANENTE ENROLLMENT AND CHANGE FORM
HMO PLAN OFFERINGS**

<p>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.</p> <p>After you have completed this form, please sign and return it to your employer's benefits office. <u>DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.</u></p> <p>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.</p>	<p>Section B: Waiver of Coverage</p> <p>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.</p>
	<p>If Making a Change Section</p> <p>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.</p>
<p>How to Complete this form – Please Print</p> <p>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.</p>	<p>Section C: Family Information</p> <p>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 Web site at http://www.kaiserpermanente.org</p>
<p>To Be Completed by Employer</p> <p>Your employer will complete this section.</p>	<p>Section D: Maximum Age/Disabled Dependent</p> <p>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.</p>
<p>Section A: Employee Information</p> <p>Please provide information about yourself. To indicate your choice of primary care provider, please see the line at the end of the section.</p>	<p>Section E: Dependents residing at another PERMANENT address</p> <p>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.</p>



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Section F: Other Coverage Information	Section G: Subscriber Sign-off
<p>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.</p> <p>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, 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 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.</p>	<p>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.</p> <p style="text-align: center;">WARNING</p> <p>ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON</p>

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM



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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.

Group number boxes

SUBGROUP NO.

Subgroup number boxes

EMPLOYEE LAST NAME

Last name input boxes

FIRST NAME

First name input boxes

MI

MI input box

SUFFIX

Suffix input boxes

Check One and indicate date of event:

New enrollment (complete all applicable sections) New enrollment Effective Date (MM/DD/YYYY)

Open enrollment (complete all applicable sections) Open enrollment Effective Date (MM/DD/YYYY)

COBRA (complete all applicable sections) COBRA Effective Date (MM/DD/YYYY)

Loss of other coverage (complete all applicable sections)

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

EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE

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

Signature and contact information fields: Printed or Typed Name/Title, Employer Signature, Date, Telephone, Fax







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)

<input type="checkbox"/> Birth**	Date of Event (MMDDYYYY)	<input type="checkbox"/> Loss of other Coverage*	Date of Event (MMDDYYYY)
<input type="checkbox"/> Adoption*	<input type="text"/>	<input type="checkbox"/> Marriage*	<input type="text"/>
<input type="checkbox"/> Address (complete sections A, G)		<input type="checkbox"/> Telephone (complete sections A, G)	
<input type="checkbox"/> Name Change* _____		<input type="checkbox"/> 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)

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> DOMESTIC PARTNER (If eligible under your plan)
LAST NAME	FIRST NAME	MI	SUFFIX
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Care Provider (PCP) Name _____		PCP ID# <input type="text"/>	

<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER _____
LAST NAME	FIRST NAME	MI	SUFFIX
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SOCIAL SECURITY NUMBER	MEDICAL RECORD NO.	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Care Provider (PCP) Name _____		PCP ID# <input type="text"/>	

*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:

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 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.

Request for Cancellation

I hereby request on behalf of myself and each dependent listed above, that my coverage be cancelled.

WARNING: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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



