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 Medicare Advantage/Senior Advantage, Please Provide the Following Information

Please indicate which Kaiser Permanente **region** you reside in and wish to enroll:

☐ **COLORADO** ☐ **GEORGIA** ☐ **MID-ATLANTIC STATES** ☒ **NORTHWEST** ☐ **WASHINGTON**

Employer or Union Name: City of San Jose, Office of Retirement Services

Group #: 4189-001

LAST Name:

FIRST Name:

Middle Initial:

Gender: ☐ Male ☐ Female

Home Phone Number:

Mobile 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:
6. Requested effective date (subject to CMS approval):

Last Name _____ First Name _____

For Washington region only – Selecting a primary care provider:

If you have a current primary care provider who contracts with Kaiser Foundation Health Plan of Washington (primary care providers do not include specialists) and you would like to continue seeing that physician, please include his/her name here.

_____

(If you are a current Kaiser Permanente member and are not making a primary care provider change, please leave blank.)

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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Last Name _____ First Name _____

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 your Kaiser Permanente region at the phone number listed on the instruction page 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 Medicare Advantage/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 (subject to CMS approval): _____

Last Name _____ First Name _____

Please Read and Sign Below

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 Medicare Advantage/Senior Advantage plan because I can be enrolled in only one Medicare Advantage/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 Medicare Advantage/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 Medicare Advantage/Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that beginning on the date Medicare Advantage/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 Medicare Advantage/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.**

For Northwest region only: Any services received under the Outside Service Area Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente.

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 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.

Last Name | First Name

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.

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.

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):

Last Name _____ First Name _____

For CO, GA, NW & WA regions – Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____

For MAS region – Office Use Only:

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

Plan ID #: _____

PBP#: ☐ H2172-801 ☐ H2172-803 ☐ H2172-804 ☐ H2172-805

Group Number: _____ Subgroup Number: _____

Employer Subsidy Group: ☐ Yes ☐ No Part D Group: ☐ Yes ☐ No

ICEP/IEP: _____ AEP: _____ SEP (type): _____