IMPORTANT INFO – Read all pages of the enrollment form before signing

Completing and returning the enrollment 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 the enrollment form, call our Customer Service Center at 1-800-805-2739 (TTY 711), seven days a week, 8 a.m. to 8 p.m.

ABOUT THE ENROLLMENT PROCESS - Submitting your enrollment form

• If you are completing a paper form:
  1. Remove the perforated tab at the top of the page.
  2. Separate all pages BEFORE filling out the form.
  3. Fill out the separated pages completely.
  4. Mail the original signed form (top copy) in the enclosed postage-paid envelope.
  5. Keep the bottom copy for your own records.

• If you downloaded the form online:
  1. Print out the form.
  2. Fill out the form completely.
  3. Make a copy for your own records.
  4. Mail the original signed form to
     Kaiser Permanente – Medicare Unit
     P.O. Box 232407
     San Diego, CA 92193-9914.

• 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.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information:

Please check which plan you want to enroll in:

- Maui Basic Plan (HMO) - $0 per month
- Maui Enhanced Plan (HMO) - $144 per month
- Oahu Basic Plan (HMO) - $0 per month
- Oahu Enhanced Plan (HMO) - $144 per month

Would you also like to add optional supplemental benefits (i.e., Advantage Plus) for an additional $22 per month to your Kaiser Permanente Senior Advantage plan?  Yes  No

Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium and any other applicable Medicare premium(s), if not otherwise paid by Medicaid or another third party.

Last Name: FIRST Name: Middle Initial:  Mr.  Mrs.  Ms.

Birth Date: (_____ / _____ / ______) Sex:  □ M  □ F  Home Phone Number: ( )  Alternate Phone Number: ( )

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

City:  County:  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.

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KAH1905

Top original signed copy - Kaiser Permanente
Bottom copy - Keep for your records
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 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 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): __________________________

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 us to send you information in a language other than English or in another format:
☐ Spanish
☐ Large Print  ☐ Braille  ☐ CD  ☐ Cassette

Please contact Kaiser Permanente at 1-800-805-2739 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711.

STOP
Please Read This Important Information

If you currently have health coverage from an employer or union, joining Kaiser Permanente Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Kaiser Permanente 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 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. 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 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 Kaiser Permanente 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 Kaiser Permanente 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.

Optional supplemental benefits conditions of enrollment

By completing this enrollment application:

• I agree to adding the Advantage Plus optional supplemental benefits package that gives me dental, hearing aid, and additional eyewear for $22 per month, which is in addition to my Medicare and Kaiser Permanente Senior Advantage premiums.

• I understand that the dental, hearing aid, and additional eyewear supplements my Senior Advantage coverage and is subject to the terms and conditions stated in the Kaiser Permanente Senior Advantage Evidence of Coverage.

• I understand that the Advantage Plus optional supplemental benefits package is only available to members enrolled in a Kaiser Permanente Senior Advantage Individual Plan.

• I understand that I must get covered care from network providers, except for emergency or urgently needed services.

• I understand that I can disenroll from Advantage Plus coverage at any time. If I disenroll, I will not be eligible to enroll until the next Advantage Plus annual election period for coverage effective January 1, 2016.
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: __________
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 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 1-800-805-2739 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, from 8 a.m. to 8 p.m.