

Kaiser Permanente Medicare Plus (Cost)

Group Enrollment Form

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

2101 East Jefferson Street, Rockville, MD 20852



KAISER PERMANENTE®

kp.org/medicare

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

Completing and returning this form is your first step to becoming a Kaiser Permanente Medicare Plus member. If you and your spouse are both applying, you will each need to complete a separate form. If you have any questions concerning benefits and services that are provided by or excluded under this agreement, or for help completing this form, call Member Services, seven days a week, between 8 a.m. and 8 p.m., toll free at **1-888-777-5536**, or **TTY 711** before signing this form.

ELIGIBILITY

1. You may not enroll in Kaiser Permanente Medicare Plus if you currently have End-Stage Renal Disease (ESRD) unless:
 - a. You are a member of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in good standing and were diagnosed with ESRD during your current membership,
 - b. You had a successful kidney transplant 36 or more months ago, or
 - c. You do not need regular dialysis anymore.

Please attach a note or records from your doctor if items b or c above applies to you.

2. We need verification that you are enrolled in Medicare Part B and that you live within our Kaiser Permanente Medicare Plus service area for us to enroll you.

HOW TO FILL OUT THIS FORM

1. Separate all the pages.
2. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
3. Sign the form on page 5 and date it. **Make sure you've read all the pages before you sign.**
4. Make a copy for your records.
5. **Mail the completed form to DC Government Benefits: email to Benefits.DCHR@dc.gov, or mail to District of Columbia Department of Human Resources, Attn: Benefits and Retirement Administration, 1015 Half Street, SE, 9th Floor Washington, D.C. 20003**
 - **Do not drop off your application at a Kaiser Permanente Medical Center as this may delay your enrollment.**

When we receive your application, we will verify your eligibility for Medicare Parts A and B or Part B only. Upon acceptance, we will send you a letter that tells you the date your coverage becomes effective. Later, we will send your Kaiser Permanente Medicare Plus identification card. You should not disenroll from any Medicare supplemental plan or Medigap or Medicare Select Plan until you receive written notification from us confirming that Medicare has approved your enrollment.

Name

Kaiser Permanente Medical Record Number

A. To Enroll in Kaiser Permanente Medicare Plus, Please Provide the Following Information:

Please indicate your requested enrollment effective date (mm/dd/yyyy) / /

LAST Name:

Mr. Mrs. Ms.

FIRST Name:

Middle Initial:

Gender:

M F

Phone Number:

- -

Birth Date: (mm/dd/yyyy)

/ /

Permanent Residence Street Address:

City:

County:

State:

ZIP Code:

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

Street Address:

City:

State:

ZIP Code:

E-mail Address:

Name of Employer providing retiree health benefits:

Under Medicare regulations, a Medicare beneficiary can be enrolled in only one Medicare health plan or Medicare Prescription Drug Plan at a time. If you currently have Kaiser Permanente coverage through more than one employer or trust fund, you must choose only one of these coverages for your Medicare Plus plan. Your other employer may allow you to maintain your non-Medicare coverage as well. We suggest that you contact the benefit administrators at each of your employers or trust funds to understand the employer or trust fund coverage that you are entitled to before you make a decision about which coverage to choose for your Medicare Plus plan.

Warning MD residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Name

Warning DC residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Warning VA residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to other actions as allowed by law.

B. 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.

You must have Medicare Part B to join a Medicare Cost plan.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To

Hospital (Part A) Effective Date:

/ /

Medical (Part B)

/ /

C. Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? Yes No

Do you have health coverage through your or your spouse's current or former employer?

Yes No

If "yes," please provide the following information or attach a copy of both sides of your health insurance card:

Employer Name

Employer Address

Policy Holder Name

Policy Number

Name of other coverage

Effective Date (mm/dd/yyyy) / /

Name

3. Are you enrolled in your State Medicaid program? Yes No

If "yes," please provide your Medicaid number

4. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse's employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Do you or will you have other prescription drug coverage in addition to Kaiser Permanente Medicare Plus? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage or provide a copy of your prescription drug card::

Name of other coverage	ID # for this coverage	Group # for this coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Have you ever been or are you now a Kaiser Permanente member?

Yes, current member Yes, previous member No

If yes, please list medical record number

Please check one of the boxes below if you would prefer us to send you information in another format:

Braille Large Print CD

Please contact Kaiser Permanente at **1-888-777-5536** 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**.



D. Please Read the following and Sign on Page 5:

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

Kaiser Permanente Medicare Plus is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to Kaiser Permanente Medicare Plus or by calling **1-800-MEDICARE, (1-800-633-4227)** anytime, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Call (202) 442-7627 or send an email to Benefits.DCHR@dc.gov

Name

For Medicare Plus/FEHB members only: I understand if I disenroll from Kaiser Permanente Medicare Plus for Federal Employees, it means ending my membership in Kaiser Permanente Medicare Plus but continuing to be a member of Kaiser Permanente through the Federal Employees Health Benefits Program (FEHBP). I will continue to receive care from Kaiser Permanente plan providers (although my copays and coinsurance will change). If I wish to discontinue my membership in Kaiser Permanente FEHBP, I must contact my employing office or retirement office to find out how to change to a different FEHBP health plan.

Kaiser Permanente Medicare Plus serves a specific service area. If I move out of the area that Kaiser Permanente Medicare Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that, if I am already a member of a Kaiser Permanente non-Medicare plan, this application does not automatically disenroll me from the plan in which I am enrolled. I will need to place my intent to disenroll from my current Kaiser Permanente plan in writing.

Once I am a member of Kaiser Permanente Medicare Plus, 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 Medicare Plus when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

I understand that beginning on the date Kaiser Permanente Medicare Plus coverage starts, in order for Kaiser Permanente Medicare Plus to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by Kaiser Permanente Medicare Plus. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Kaiser Permanente Medicare Plus and other services contained in my Kaiser Permanente Medicare Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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.

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 is necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente Medicare Plus 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 any misrepresentation of information may void my membership and benefits retroactively to the date Kaiser Permanente benefits began and Kaiser Permanente has the right to pursue payment for services rendered. I will be entitled to a refund of paid premiums from the date of coverage being voided or rescinded.

Name

I understand that my signature (or the signature of the person authorized to act on my behalf under State law 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 by Kaiser Permanente Medicare Plus or by Medicare.

Your Signature:

Today's Date: / /

If you are the authorized representative, you must provide the following information:

Name:

Address:

Phone Number: - -

Relationship to Enrollee:

D.C. GOVERNMENT RETIREES MEDICARE PLAN

Office Use Only:

Name of Staff member (if assisted in enrollment):

Plan ID#

PBP# H2150-801 H2150-805 H2150-806 H2150-807 H2150-017 H2150-030

Group Number Subgroup Number

Employer Subsidy Group Yes No

Part D Group Yes No

IEP AEP SEP (type)

You must continue to pay your Part B premium. Kaiser Permanente is a Cost Plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - ◆ Qualified sign language interpreters.
 - ◆ Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
 - ◆ Qualified interpreters.
 - ◆ Information written in other languages.

If you need these services, call Member Services at **1-888-777-5536 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

In Maryland and the District of Columbia, Kaiser Permanente is an HMO plan and a Cost plan with a Medicare contract. In Virginia, Kaiser Permanente is a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-777-5536** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-777-5536** (TTY: **711**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-777-5536** (TTY: **711**)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-777-5536** (TTY: **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-777-5536** (TTY: **711**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-777-5536** (TTY: **711**)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-777-5536** (телетайп: **711**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-777-5536** (TTY:**711**) まで、お電話にてご連絡ください。

Thai: 注意: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-777-5536** (TTY: **711**).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-777-5536** (TTY: **711**) पर कॉल करें।

Amharic: ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-888-777-5536** (መስማት ለተሳናቸው: **711**).

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیری **1-888-777-5536** (TTY: **711**) فراهم می باشد. با

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-777-5536** (رقم هاتف الصم والبكم: **711**).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-777-5536** (TTY: **711**).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-777-5536** (ATS : **711**).

Yoruba: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-888-777-5536** (TTY: **711**).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-777-5536** (TTY: **711**).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-777-5536** (TTY: **711**).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-888-777-5536** (TTY: **711**)।

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-888-777-5536** (TTY: **711**).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-777-5536** (TTY: **711**).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-777-5536** (TTY: **711**).