KAISER PERMANENTE®
Senior Advantage

ELECTION FORM

Important information about this election form

PLEASE READ ALL PAGES BEFORE SIGNING THIS FORM.

Please type or print legibly, using a black or blue ballpoint pen, and press firmly.

- Completing and returning this election form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are applying, please complete one form per person. If your name and address information is preprinted, review it carefully and make any necessary corrections. If you have any questions about completing this form, please contact the Kaiser Permanente Member Service Call Center at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing or speech impaired), seven days a week, from 8 a.m. to 8 p.m.
- You are entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this election form signifies that you have read, understand, and agree to these provisions.
- To enroll, you will need verification that you are entitled to Medicare Part A and enrolled in Medicare Part B and **you must live in a Kaiser Permanente Senior Advantage service area.**
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is true:
  - Your date of diagnosis was while you were already a Kaiser Permanente member, and you are enrolling during an allowable election period.
  - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
  - You have had a successful kidney transplant, and you attach a note or records from your doctor showing that you have had a kidney transplant and no longer need regular dialysis.

If you receive health coverage through an employer or trust fund, joining Kaiser Permanente Senior Advantage may affect your current health care benefits. Please carefully review any information that your employer or trust fund sends you. If you have questions about how your current coverage may be affected, contact your employer or trust fund's benefits administrator.

About the application process

After completing pages 1 and 2 of this election form, please read the sections titled "Kaiser Foundation Health Plan Arbitration Agreement," "Authorization to Exchange Information," and "Conditions of Election" at the end of this form. Then sign and date page 3. **Keep the pink copy of this election form for your records.** If required, send the bottom white copy to your employer group or trust fund. Return the top, signed white copy to:

California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

- Once we receive your election form, we screen it for completeness and signatures, and we then acknowledge receipt by mail.
- We notify Medicare that you have applied to join Kaiser Permanente Senior Advantage.
- Within seven business days after Medicare confirms your eligibility, we confirm the effective date of your coverage.
- You may receive a Kaiser Permanente ID card and information for new members.

To enroll in Kaiser Permanente Senior Advantage, please provide the following information:

Last Name			First Name	Middle Initial
Permanent Residence (Street Address ONLY — No P.O. Box)				
City	State	ZIP Code	County of Residence	
Mailing Address if different from Permanent Residence				
City	State	ZIP Code	Daytime Phone	Evening Phone
E-mail Address (optional)			Date of Birth / /	
Sex ☐ Male ☐ Female	Social Security number (providing this information is optional)			

- As a Kaiser Permanente Senior Advantage member, will you be covered through your or your spouse's employer group or trust fund plan? ☐ yes ☐ no

  Employer group/trust fund name (if applicable) _____

  Employer group ID # (if applicable) _____

- Were you a member of any Kaiser Permanente health plan in the past? ☐ yes ☐ no

  If you answered yes to the previous question, please provide your Kaiser Permanente medical record number (MRN) _____

Please answer the following questions (the information you provide will not be used for health screening purposes). ***Failure to answer any question may result in a delay of the application process.***

1. Do you currently have end-stage renal (kidney) disease (ESRD)? ☐ yes ☐ no

   If yes, date of diagnosis _____/_____/_____

   See the section titled "Important information about this election form" on the cover page for additional information about enrolling with ESRD.

2. Are you enrolled in Medi-Cal (state-subsidized medical plan)? ☐ yes ☐ no

   If yes, please provide your Medi-Cal number _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ yes ☐ no

   Name of institution _____

   Address (number and street) and phone number of institution _____

   _____

4. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs? ☐ yes ☐ no

   If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit **www.medicare.gov** or call **1-800-MEDICARE (1-800-633-4227),** 24 hours a day/7 days a week. TTY/TDD users should call **1-877-486-2048,** 24 hours a day/7 days a week.

Last Name: _____ First Name: _____

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs.

   Will you have other *prescription* drug coverage in addition to Kaiser Permanente Senior Advantage prescription drug coverage? ☐ 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 _____

For Individual Plan Members ONLY

As an Individual Plan member (**not** covered through an employer or trust fund), you can have the monthly premium for this Medicare plan automatically deducted from your Social Security or other benefit check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or by electronic funds transfer (EFT). Generally, you must stay with the option that you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose whether you want the remaining premium, if there is any, deducted from your monthly check.

Please contact us at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, from 8 a.m. to 8 p.m., to tell us whether you want to pay us directly each month, or whether you want the premium for this plan automatically deducted from your Social Security benefit check.

Medicare health insurance card information

Please complete this sample Medicare health insurance card with the information found on your own Medicare card. Please copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from the Social Security Administration or Railroad Retirement Board) that provides the same information.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Health Insurance
SOCIAL SECURITY ACT

Name
➤ _____

Medicare claim number ➤ _____ Sex ➤ _____

is entitled to Effective date

Hospital Insurance Part A ➤ _____

Medical Insurance Part B ➤ _____

For Employer Group/Trust Fund Members ONLY

Requested Effective Date _____

INTERNAL USE ONLY

Date Stamp _____ Language Preference _____ Rep's Name _____

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

Last Name: _____ First Name: _____

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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 my 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.*

Authorization to Exchange Information

- I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to furnish information to Kaiser Foundation Health Plan, Inc., confirming my Part A (hospital), Part B (medical), and Part D (drug) Medicare enrollment and, if my Medicare enrollment is terminated, the effective date of termination.
- I also authorize Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., or the Southern California Permanente Medical Group, or any holder of medical or other information about me, to release to CMS, or its intermediaries or carriers, any information needed to administer Title XVIII (the Medicare Section) of the Social Security Act.

PLEASE READ THE *CONDITIONS OF ELECTION* ON THE REVERSE SIDE OF THIS FORM.

I have read, understand, and agree to the statements in this election form, including the restrictions on the use of non-Plan providers. I hereby apply for Kaiser Permanente Senior Advantage membership.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 or by Medicare.

Applicant signature _____ Date _____

OR

Signature of representative by law _____

Representative name (please print) _____ Date _____

Signature of any person who assisted in completing this form (required if applicable) _____ Date _____

Name (please print) _____ Relationship _____

Address _____ Phone _____

Conditions of Election

Please read the following statements carefully before you sign this form:

If you are electing Kaiser Permanente Senior Advantage coverage, be certain that you fully understand the arbitration provision, benefits, limitations, and conditions that are described in the *Group Disclosure Form (Group DF), Group Evidence of Coverage (Group EOC),* and/or *Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage (DF/EOC)*. These documents can be found in the enrollment kit or will be mailed to you within 30 days of enrollment. The documents are also available upon request by calling our Kaiser Permanente Member Service Call Center at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, from 8 a.m. to 8 p.m.

- I will abide by Health Plan policies and rules that apply to me.
- I understand that I cannot belong to another Medicare Advantage plan or Medicare Advantage Prescription Drug Plan and Kaiser Permanente Senior Advantage at the same time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan in which I am currently a member.
- I understand that I can be a member of only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. I cannot enroll in more than one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan with the same effective date. If I do so, the election form with the latest signature date will be processed by the Centers for Medicare & Medicaid Services (CMS). It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- I understand that, in general, I can change health plans or return to Original Medicare during certain times of the year only.
- I understand that, in general, there are limitations to the number of times that I can change my health plan choices during the year.
- I have read and I understand the limitations and exclusions of Senior Advantage coverage contained in the Senior Advantage *Individual Plan DF/EOC* or the Senior Advantage *Group DF*.
- I understand that I must maintain my enrollment in Medicare Part A and Part B insurance.
- I understand that I will be notified by mail of the effective date of my Senior Advantage coverage. The effective date of my coverage will be determined by the date that Health Plan receives my completed Senior Advantage election form. I understand that there are exceptions to these rules, as described in the *Group DF* and/or *Individual Plan DF/EOC*. I also understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare Select plan until I receive confirmation from the Medicare Advantage plan.
- I understand that I must enroll in the Kaiser Permanente Senior Advantage service area in which I reside. Further, I understand that it is my obligation to notify Kaiser Permanente if I permanently move or leave the service area and that my absence means that Kaiser Permanente may take action to disenroll me. I also understand that if I move from one California Kaiser Permanente Senior Advantage service area to another, I must complete a new election form, and that benefits, copayments, and premiums may differ.
- I understand that I may disenroll from Senior Advantage membership by submitting a written request to Kaiser Permanente, or by calling **1-800-MEDICARE (1-800-633-4227),** 24 hours a day/7 days a week. TTY/TDD users should call **1-877-486-2048,** 24 hours a day/7 days a week. The date of my disenrollment will be determined by the date that the written request is received by Health Plan and is verified by CMS. I understand that there are exceptions to these rules, as described in the *Group DF* and/or *Individual Plan DF/EOC.*
- If I am a Medicare Cost member, I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot enroll or re-enroll in this plan.
- I understand that, starting on the effective date of my coverage, I must receive all my medical care from Kaiser Permanente, except for emergency care, urgent care, or dialysis care while temporarily outside the service area, or authorized referrals. Neither Medicare nor Kaiser Permanente will pay for doctor or hospital care received from non–Kaiser Permanente physicians/facilities (non-Plan providers), except for emergency care, urgent care, or dialysis care while temporarily outside the service area, or authorized referrals. The definitions of these terms are in the *Group DF* and/or *Individual Plan DF/EOC,* which I have received. I have read and I understand these definitions.
- I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the Plan.

Please read carefully before you sign this form.