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

Kaiser Permanente Insurance Company (KPIC)
One Kaiser Plaza
Oakland, CA 94612

KFHP-MAS/KPIC MID LARGE GROUP ENROLLMENT AND CHANGE FORM HMO PLAN AND FLEXIBLE CHOICE OFFERINGS

INSTRUCTIONS

Welcome

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) and Kaiser Permanente Insurance Company (KPIC). We look forward to receiving your Enrollment and Change form. If you have any questions concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired before signing this form.

After you have completed this form, please sign and return it to your employer's benefits office. **Do not send this form to KFHP-MAS/KPIC unless otherwise instructed.**

If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired for more information.

How to complete this form. Please print

Use this form to enroll, waive, or change (add or delete) your family's membership status. To be a subscriber, you must live, work, or reside within our service area and you must be an employee who meets all of your employer's eligibility guidelines. **If you elect to waive coverage, you only need to complete Sections A and C.** If you have any questions, contact your employer's benefits office.

Section A: Applicant information
Please provide information about yourself.

Section B: Benefit plan requested
Please provide information for the plan that you are selecting.

Section C: Waiver of coverage
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 C.

Section D: Family information
Make sure your dependents, if offered by your employer, meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office.

Maximum age/disabled dependent
Please complete this section to list any dependents who 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.

Dependents residing at another PERMANENT address
Please use this section to document any dependents who have a 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.

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Section E: Other coverage
Tell us if you, your spouse [domestic partner], if offered by your employer, or other family dependents are covered by other group health insurance plans. This may occur when both spouses [domestic partners] 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. If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS/KPIC 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 and Workers' Compensation, so long as you are enrolled in the primary plan and such plan remains primary to KFHP-MAS/KPIC plan. Your signature authorizes KFHP-MAS/KPIC and its employees 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 [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired.

Section F: Subscriber signature
Review and sign this form. Before doing so, 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.

Section G: Employer Authorized Representative
To be completed by the employer.

WARNING: If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties.

KAISER PERMANENTE

KFHP-MAS/KPIC MID LARGE GROUP ENROLLMENT AND CHANGE FORM HMO PLAN AND FLEXIBLE CHOICE OFFERINGS

Company name	**Effective date**	**Date of qualifying event**	**Group number**

❑ New enrollment ❑ Self only ❑ Self and dependent(s) ❑ Open enrollment ❑ New hire	❑ Qualifying life event ❑ COBRA ❑ Rehire/reinstatement ❑ Waiver ❑ Other ____________	❑ Change of coverage ❑ Add spouse [or domestic partner]* ❑ Add dependent child* ❑ Name change* ❑ Other ___________________	❑ Employee termination ❑ Remove spouse [or domestic partner]* ❑ Remove dependent child* ❑ Cancel coverage

A. APPLICANT'S INFORMATION. Must be completed by the employee

EMPLOYEE LAST NAME FIRST NAME MI SUFFIX

ADDRESS

APARTMENT # CITY

STATE ZIP CODE HOME PHONE WORK PHONE

Social security number	Date of birth	
☐☐☐-☐☐-☐☐☐☐	☐☐/☐☐/☐☐☐☐	Male ☐ Female

Email address

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS? ❑ Yes ❑ No	**Check One:** ❑ Full-time ❑ Part-time ❑ 1099 Contractor ❑ Seasonal ❑ Temporary ❑ Retiree

If you do not physically work at your employer's address, please provide your working address:

*Additional documentation may be required

B. BENEFIT PLAN REQUESTED

Choose only one Group Health Plan selected by your employer

MEDICAL		DENTAL ENHANCEMENTS (OPTIONAL)
Product*	**Service delivery options****	❑ **Employer-selected adult dental rider**
HMO	❑ Signature ❑ Select	Dental benefits are underwritten by KFHP-MAS
Deductible HMO	❑ Signature ❑ Select	
HSA-Qualified Deductible HMO (HDHP)	❑ Signature ❑ Select	
CDHC Options (Available if a KP health plan is purchased): ☐ KP Administered HSA (available with HDHP only) ☐ KP Administered HRA (available with HMO, DHMO, HDHP) ☐ KP Administered FSA (available with HMO, DHMO, HDHP) ☐ KP Administered HRA/FSA (available with HMO, DHMO, HDHP)		
Added Choice POS	❑ Signature ❑ Select	
Flexible Choice POS	Signature Only	
Out-of-Area PPO		

***Benefits underwritten by KFHP-MAS:**
HMO
DHMO
HDHP
Option 1 of Flexible Choice POS
Added Choice POS

Benefits underwritten by KPIC:
Option 2 and Option 3 of Flexible Choice POS,
and Out-of-area PPO

****The Service Delivery Options only apply to the benefits underwritten by KFHP-MAS. The Service Delivery Options do not apply to the products underwritten by KPIC.**

C. 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 [or domestic partner] ❑ Coverage for my child(ren) *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:** ❑ Other group coverage sponsored by my spouse's [or domestic partner's] employer* ❑ Other group coverage sponsored by another organization* ❑ Medicare/Medicaid/TRICARE* ❑ Individual coverage* ❑ Parental coverage (must be under 26 or disabled)* ❑ Other reasons (please explain) _____
Waiving employee signature	**Date**

*Additional documentation may be required.

D. FAMILY INFORMATION. Must be completed by the employee.

If additional space is needed, please use another form and attach to this form.

SPOUSE [OR DOMESTIC PARTNER] (If eligible under your plan)

LAST NAME	FIRST NAME	MI	SUFFIX

Social security number ☐☐☐-☐☐-☐☐☐☐ Date of birth ☐☐/☐☐/☐☐☐☐ Relationship

Male

Female

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social security number ☐☐☐-☐☐-☐☐☐☐ Date of birth ☐☐/☐☐/☐☐☐☐ Relationship

Male

Female

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social security number ☐☐☐-☐☐-☐☐☐☐ Date of birth ☐☐/☐☐/☐☐☐☐ Relationship

Male

Female

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social security number ☐☐☐-☐☐-☐☐☐☐ Date of birth ☐☐/☐☐/☐☐☐☐ Relationship

Male

Female

Are any of your listed dependents over the Groups' maximum age(s)? If yes, please complete the following:

Name(s) (last, first, MI)	Disabled*	Reason
	❑ Yes ❑ No	
	❑ Yes ❑ No	

*Additional documentation may be required.

Do any of your dependents above permanently reside at another address?

❑ Yes** ❑ No If yes, please complete the following:

Dependent last name	First name	M.I.
Home address		Apt. number
City	State	ZIP code

**If additional space is needed, please use another form and attach it to this form.

E. OTHER COVERAGE

Including yourself, do any of the persons listed below have other health coverage? ❑ Yes ❑ No

Name	Insurance carrier name	Policy number	Telephone number

Are you or any of your dependents eligible for Medicare? ❑ Yes ❑ No

F. SUBSCRIBER SIGNATURE

❑ 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 KFHP-MAS/KPIC, I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay required 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 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.

You may also be liable to KFHP-MAS/KPIC for the cost of health care services provided because of the false or misleading information or omission.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this enrollment card.

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

G. EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE

I hereby certify that this (these) enrollment(s) has been reviewed and meet(s) all eligibility requirements.

Printed or typed name	Title	Phone number
Employer signature		Date

*Additional documentation will be required.
†† May require additional information

[*CONTROL#./BARCODE*]