KAISER PERMANENTE®

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Kaiser Permanente for Individuals and Families

Account Change Form

Maryland

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St.
Rockville, MD 20852

Instructions

There are different types of plan and account changes you can make with this form. Please fill out your information in Section A. Next, select your enrollment period in Section C. Then, look at the options in Section D and complete the section(s) for the plan or account change(s) you would like to make. Remember, this new enrollment will not end other coverage through Maryland Health Connection or Kaiser Permanente. Don't want 2 plans? Be sure to end your other plan the day before your new plan starts to avoid paying 2 premiums and having a gap in your coverage.

A. Fill out your information

☐ Check here if your address or phone number has changed.

Please select one: I'm the ☐ subscriber, ☐ new subscriber, or ☐ person responsible for payment.

First name | MI

Last name | Date of birth (mm/dd/yyyy)

Medical record number (if any) | Social Security number (if any) | Phone

Home address (no P.O. boxes, please)

City | State | ZIP code

Billing address ☐ Check if the same as the home address.

City | State | ZIP code

B. Check your eligibility

Are you or anyone else in your family either entitled to Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No

If you selected "Yes," those of you who are entitled to Medicare Part A or enrolled in Medicare Part B can't enroll in an individual and family plan. If you're already enrolled in one, you can't change to a different individual and family plan. But, you can keep your current plan. Or you can visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for coverage.

C. When are you making a change?

To make a plan or account change (except for ending coverage), you must either be in the annual open enrollment period or in a special enrollment period. For more about special enrollment periods and determining the date of your triggering event (or qualifying life event), including required documentation that you may need to submit, visit **kp.org/specialenrollment** or call **1-800-494-5314.**

Please select only **one:**

- ☐ I'm making a change during open enrollment.
- ☐ I'm making a change during a special enrollment period.

If you're applying during a special enrollment period, please write the date of your triggering event.

Date (mm/dd/yyyy)

If you selected "A special enrollment period," choose the triggering event:

- ☐ Loss of health care coverage (write the last full day you had coverage)
- ☐ Gaining or becoming a dependent through marriage
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
- ☐ Losing a dependent through divorce or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Change in eligibility for federal financial assistance through Maryland Health Connection
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Maryland Health Connection

D. What change(s) do you want to make?

Please check the boxes for the changes you wish to make, and in Section E, list each family member who is affected. If there are other members on your account who aren't listed, we will not make any changes for them.

- ☐ I'm ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.
- ☐ I wish to switch the subscriber and spouse/domestic partner roles on our current plan.
- ☐ I wish to combine accounts. (Please pick your plan on page 3.)
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.
- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ I wish to change plans. (Please select your plan on page 3.)
- ☐ I wish to add medical coverage for a family member/domestic partner.
- ☐ I wish to end medical coverage for a family member/domestic partner.
- ☐ I wish to add adult dental coverage (for members 19 and older).
- ☐ I wish to end adult dental coverage.

E. Which family members are affected by the change? (Please list below.)

If you have more than 2 dependents with a change, attach another form and complete just the information for those dependents.

Spouse/Domestic partner

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage

First name | MI | Last name | Choose one: ☐ Spouse ☐ Domestic partner

Social Security number (if any) ___ - ___ - ____ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __ / __ / ____ | Gender: ☐ Male ☐ Female

Dependent 1

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___ - ___ - ____ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __ / __ / ____

Dependent 2

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___ - ___ - ____ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __ / __ / ____

F. Choose your health plan

If you indicated that you would like to change plans or add medical coverage for a family member, please select the plan you would like. Each family member you listed on page 2 will be moved into the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan.

- ☐ KP MD Bronze 6500/50/Dental
- ☐ KP MD Bronze 6200/20%/HSA/Dental
- ☐ KP MD Bronze 5500/50/Dental
- ☐ KP MD Silver 6000/35/Dental/Off
- ☐ KP MD Silver 3000/30/Dental/Off
- ☐ KP MD Silver 2750/20%/HSA/Dental/Off
- ☐ KP MD Silver 2000/30/Dental/Off
- ☐ KP MD Gold 1500/20/Dental
- ☐ KP MD Gold 1000/20/Dental
- ☐ KP MD Gold 0/20/Dental
- ☐ KP MD Platinum 0/5/Dental
- ☐ KP MD Catastrophic 7350/0/Dental*

*To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your account change without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

G. Enhanced Dental HMO Rider

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. Preventive adult dental is also included for members 19 and older. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

- ☐ Yes. I would like to enhance my dental coverage by selecting a Dental HMO Rider for each member age 19 and older who is applying for medical coverage.
- ☐ No. I'm not interested in the optional adult dental coverage.

H. Sign the form

I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.

- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 301-468-6000 or 1-800-777-7902 before signing this application.**
- **WARNING: 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.**

For all account and plan changes, the subscriber and all dependents 18 and older making a change must sign.

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Subscriber/new subscriber (parent or legal guardian for subscribers under 18)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Dependent (18 and older)

Contact information

Mail to: Employer Services Dept./
KPIF 5W Kaiser Permanente
for Individuals and Families
2101 East Jefferson St.
Rockville, MD 20852-9995

Or fax toll free to:
Membership Administration
1-855-414-2796

Questions? Call
301-468-6000 or **800-777-7902**

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan 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 **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan 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 by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (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。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).