

Kaiser Permanente Medicare Advantage/Senior Advantage (HMO)

## Group Medicare Election/Enrollment Form

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Medicare Advantage/Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call Kaiser Permanente at the phone number listed below for your region, seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

**California Region** 1-800-443-0815  
**Colorado Region** 1-800-476-2167  
**Georgia Region** 1-800-232-4404  
**Hawaii Region** 1-800-805-2739  
**Mid-Atlantic States Region** 1-888-777-5536  
**Northwest Region** 1-877-221-8221

(NW Oregon, SW Washington,  
and Lane County, OR)

**Washington Region** (Counties: Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Grays Harbor (ZIP codes: 98541, 98557, 98559, 98568), and Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592))  
**1-800-581-8252** (calling this number will direct you to a licensed Medicare sales specialist)

### How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

Kaiser Permanente - Medicare Unit  
P.O. Box 232400  
San Diego, CA 92193-2400

You can also FAX or EMAIL your completed form to:

FAX: 1-855-355-5334  
EMAIL: 8553555334@fax.kp.org

4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

### Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Medicare Advantage/Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit [kp.org/medicare/applicationstatus](https://www.kp.org/medicare/applicationstatus) (does not apply to Washington region).



**Employer Group Use Only**

Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #:  Employer Receipt Date:

Authorized Rep:

**To Enroll in Kaiser Permanente Medicare Advantage/Senior Advantage, Please Provide the Following Information**

Please indicate which Kaiser Permanente **region** you reside in and wish to enroll:

CALIFORNIA  COLORADO  GEORGIA  HAWAII  MID-ATLANTIC STATES  NORTHWEST  WASHINGTON

Employer or Union Name:  Group #:

LAST Name:

FIRST Name:  Middle Initial:  Gender:  Male  Female

Are you a current or former member of any Kaiser Permanente health plan?  Yes  No If yes:  Current  Former Kaiser Permanente Medical/Health Record Number:

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

City:

County:  State:  ZIP Code:

Home Phone Number:  Mobile Phone Number:  Birth Date: (mm/dd/yyyy)

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

Street Address:

City:  State:  ZIP Code:

Email Address:

Last Name  First Name

**Please Provide Your Medicare Insurance Information**

Please take out your red, white and blue Medicare card to complete this section.

Name (as it appears on your Medicare card):

- Fill out this information as it appears on your Medicare card.

Medicare Number:

- OR -

Is Entitled To:      Effective Date:  
HOSPITAL (Part A)

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

MEDICAL (Part B)

You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

**Please Read and Answer These Important Questions**

1. Do you work?  Yes  No      Does your spouse work?  Yes  No  N/A

2. Are you the retiree?  Yes  No

If yes, retirement date (mm/dd/yyyy):

If no, name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan?  Yes  No

If yes, name of spouse:

Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente?  Yes  No

If yes, please list your other coverage and your identification (ID) number(s) for that coverage.

Name of other coverage:

ID # for other coverage:

Last Name  First Name

5. 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 of institution (number and street):

Phone Number:

6. Requested effective date (subject to CMS approval):

**For Washington region only - Selecting a primary care provider:**

If you have a current primary care provider who contracts with Kaiser Foundation Health Plan of Washington (primary care providers do not include specialists) and you would like to continue seeing that physician, please include his/her name here.

(If you are a current Kaiser Permanente member and are not making a primary care provider change, please leave blank.)

**Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:**

Spanish  Chinese  Braille  Large Print  Audio CD

If you need information in an accessible format or language other than what is listed above, please contact Kaiser Permanente at the phone number listed below for your region, seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

<b>California</b>	<b>1-800-443-0815</b>	<b>Mid-Atlantic States</b>	<b>1-888-777-5536</b>
<b>Colorado</b>	<b>1-800-476-2167</b>	<b>Northwest</b>	<b>1-877-221-8221</b>
<b>Georgia</b>	<b>1-800-232-4404</b>	<b>Washington</b>	<b>1-888-901-4600</b>
<b>Hawaii</b>	<b>1-800-805-2739</b>		

**Please complete the information below**

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Medicare Advantage/Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name:

Employer Group/Union/Trust Fund ID #:

Subgroup:

Requested effective date (subject to CMS approval):

Last Name

First Name

**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 Part B, however most employer groups require both Parts A and B. I can only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage/Senior Advantage plan because I can be enrolled in only one Medicare Advantage/Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Medicare Advantage/Senior Advantage plan.

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 Medicare Advantage/Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order 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 Medicare Advantage/Senior Advantage 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 Medicare Advantage/Senior Advantage **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.**

**For Northwest region only:** Any services received under the Outside Service Area Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente.

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.

**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 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.

Last Name

First Name

**FOR CALIFORNIA ENROLLEES ONLY:  
KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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 our 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.

**FOR HAWAII ENROLLEES ONLY:  
KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT FOR THE HAWAII REGION**

If you want to pursue a claim that is not resolved by other procedures described in this section, any and all claims, disputes, or causes of action arising out of or related to this Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Agreement. Claims subject to the Medicare appeals process are not subject to binding arbitration.

By enrolling in Kaiser Permanente Senior Advantage, you waive all rights to have these types of claims decided in a court of law. The arbitrator's decision is binding.

This includes but is not limited to any claim asserted:

1. By or against you, or a member, the heirs or the personal representative of your estate or the member's estate, or any other person entitled to bring an action for damages for harm to you or a member as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section, all family members of you or of the member who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms.
2. On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
3. By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
  - I. Kaiser Foundation Health Plan, Inc.
  - II. Kaiser Foundation Hospitals
  - III. Hawaii Permanente Medical Group, Inc.
  - IV. The Permanente Federation, LLC
  - V. Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv), or (v) above to provide to provide services to you or a patient, when such contract includes a provision requiring arbitration of the claim made.

Last Name

First Name

**Claims not subject to binding arbitration**

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

1. Claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
2. Actions for appointment of a legal guardian of a person or property subject to probate laws;
3. Purely injunctive orders reasonably necessary to protect Kaiser Permanente’s ability to safely render medical services under this Agreement (such as temporary restraining orders, and emergency court orders);
4. For members of private employer Groups, claims for benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA);
5. Claims subject to the Medicare appeals process.

**Initiating arbitration**

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in Chapter 2 of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage**. The arbitrators shall have jurisdiction only over persons and entities actually served.

**Arbitration proceedings**

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. (“DPR”). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than \$25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) shall arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for:

1. Production of documents that are relevant and material,
2. Taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation), and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
3. Independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties’ rights under this paragraph.



Last Name

First Name

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

The arbitration award shall be final and binding. You, the Member Parties and Kaiser Permanente Parties waive your/their rights to jury or court trial.

With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

**General provisions**

All claims based upon the same incident, transaction or related circumstances regarding you or the same member shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding). A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

**Confidentiality**

This Agreement concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

**Special claims**

1. **Medical Malpractice Claims.** Prior to initiating any arbitration proceedings alleging medical malpractice, you shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the termination of proceeding by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, you shall serve a demand for arbitration on Kaiser Permanente Parties as specified above.
2. **ERISA Claims.** If your plan is governed by ERISA, and you have a claim for benefits that is denied or ignored (in whole or in part), you may file suit in federal court under Section 502(a)(1)(B) of ERISA. If a suit is filed, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator, i.e., your employer or group sponsor.

Last Name  First Name

Although benefit-related claims subject to ERISA are not required to be resolved by binding arbitration pursuant to this section, you may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of Section 8-B of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage**. If a voluntary election to use binding arbitration is made by you, the arbitration shall be conducted pursuant to this Section 8-B of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage**.

- 3. Senior Advantage Member Claims. Complaints and appeals procedures are described in the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage** chapter 9 titled, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)". The arbitration provisions of this Agreement apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this Agreement, irrespective of the legal theory upon which the claim is asserted.

I acknowledge that I have read and understood the information in the Arbitration Agreement above and agree that I, on behalf of myself, all applicants, and all family members, hereby (i) acknowledge that I have read and understood the provisions of the KFHP Arbitration Agreement, (ii) agree to binding arbitration, and (iii) give up my constitutional right to a jury trial.

**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:**

Last Name  First Name

**For CA, CO, GA, HI, NW & WA regions - 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:

**For MAS region - Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #:

PBP#:  H2172-801  H2172-803  H2172-804  H2172-805

Group Number:  Subgroup Number:

Employer Subsidy Group  Yes  No Part D Group  Yes  No

ICEP/IEP:  AEP:  SEP (type):