

Application/Change Form Colorado Springs



This Kaiser Permanente form may be used for any of the following reasons:

- Enrollment/Open Enrollment
- Change of Information
- Cancellation of Coverage

Please call the Information Center at **1-888-681-7878** if:

- you would like to convert from group to individual coverage, or
- you need help completing this application

See reverse side of this page for instructions for completing this form.

Coordination of Benefits

If you and your family are covered by more than one health plan, you may be able to save money while improving your coverage.

Often, when a husband and wife are both employed, they may each have health coverage provided by their employers. If you are covered by two plans that include a Coordination of Benefits (COB) provision, you may be able to eliminate most of your out-of-pocket expenses for services now only partially covered by those plans.

When you receive services authorized by Kaiser Permanente, we will bill your primary carrier for you and set up a benefit reserve account. Kaiser Permanente will keep track of any savings we receive from your primary carrier and credit it into a benefit reserve account for you. The money in the benefit reserve account is used to reimburse you for out-of-pocket expenses for medical services that are only partially covered by either of your health plans. Incurred expenses applied to the benefit reserve account must occur in the same calendar year.

To take advantage of this benefit, be sure to complete the Coordination of Benefits information in Section 6 of this application/change form.

If you have any questions or need more information about Coordination of Benefits, call the Customer Service at **1-888-681-7878**.

Kaiser Permanente
Membership Accounting Department
P.O. Box 921010
Fort Worth, Texas 76121-1010

1-888-681-7878



Please print firmly

Application/Change Form Colorado Springs

Section 1: Product/Action

Product: HMO PPO Added Choice (Point-of-Service) Extended Choice (Out-of-Area)

Reason: New Enrollment Open Enrollment Change Cancel

Effective Date: _____ Month _____ Day _____ Year

Section 2: About You/Your Family

List employee and all eligible family members to be enrolled or those affected by a change.

Your Name, Last, First, Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Month	Birth Date Day	Year	Social Security Number	Kaiser ID# (if current member)	Primary Care Physician (PCP) Indicate if a current patient of this PCP
Your Spouse's Name, Last, First, Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Month	Birth Date Day	Year	Social Security Number	Kaiser ID# (if current member)	Primary Care Physician (PCP) Indicate if a current patient of this PCP
Your Child's Name, Last, First, Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Month	Birth Date Day	Year	Social Security Number	Kaiser ID# (if current member)	Primary Care Physician (PCP) Indicate if a current patient of this PCP
Your Child's Name, Last, First, Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Month	Birth Date Day	Year	Social Security Number	Kaiser ID# (if current member)	Primary Care Physician (PCP) Indicate if a current patient of this PCP
Your Child's Name, Last, First, Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Month	Birth Date Day	Year	Social Security Number	Kaiser ID# (if current member)	Primary Care Physician (PCP) Indicate if a current patient of this PCP

Current Address (New address, if this is a change) _____ Apt. # _____ City _____ State _____ Zip Code _____ Home Telephone Number _____

Employer Name _____ Date of Hire Month _____ Day _____ Year _____ Hours worked per week _____ Position/Title _____ Work Telephone Number _____

Emergency Contact (Name and Relationship to you) _____ Daytime Phone Number _____ Evening Phone Number _____

Kaiser Permanente Group Number _____ Sub-Group Number _____ Bill Group Number _____

Section 3: Medicare Eligibility

Are you or any of your dependents eligible for Medicare? If yes, please contact **1-888-681-7878** for details. Yes No

Section 4: Preferred Language

Primary Language spoken in the home American Sign Language Cantonese English French German Hmong Korean

Mandarin Russian Spanish Vietnamese Other _____

Section 5: Reason for Change

Please check all that apply

Add Dependent(s)	Cancel Dependent(s) Only	Cancel All Coverage	Other Changes
<input type="checkbox"/> Marriage	<input type="checkbox"/> Marriage	<input type="checkbox"/> Terminate Employment	<input type="checkbox"/> COBRA (See employer for details)
<input type="checkbox"/> Newborn	<input type="checkbox"/> Divorce Final Decree Date _____	<input type="checkbox"/> Voluntary Withdrawal	<input type="checkbox"/> Change Name/Address Former Name _____
<input type="checkbox"/> Adoption*	<input type="checkbox"/> Over-age Limit	<input type="checkbox"/> Leave/Lay Off	<input type="checkbox"/> Loss of Other Group Coverage
<input type="checkbox"/> Legal Guardianship*	<input type="checkbox"/> Deceased	<input type="checkbox"/> Moved Out of Area	Date ended _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Dissatisfied	Carrier _____
*Attach legal documentation		<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Section 6: Coordination of Benefits

Is your spouse employed? Yes No

Employer Name _____ Employer Phone Number _____

Does your spouse have additional insurance? Yes No

Insurance Carrier _____ Phone Number _____ Policy Number _____ Group Number _____

Are your children employed? Yes No

Subscriber Name _____ Employer Name _____ Employer Phone Number _____

Do your children have additional insurance? (If more than one, please attach separate page.) Yes No

Insurance Carrier _____ Phone Number _____ Policy Number _____ Group Number _____

Section 7: Conditions for Enrollment

I have read and agree to the terms and conditions on the reverse side of this form.

By enrolling in Kaiser Permanente, you agree to have all disputes and/or claims for money damages exceeding the Small Claims Court limit in Colorado, including issues of medical malpractice, decided by neutral arbitration rather than by a jury or court trial.

I hereby apply for Kaiser Permanente membership for myself and eligible family dependents listed on this form. I understand that if I/we are accepted for membership, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

I expressly authorize any doctor or hospital to furnish Kaiser Permanente any records concerning me or any other member of my family. The release of medical information may include reference to psychiatric illness, alcohol or drug abuse, information related to HIV, AIDS and other communicable diseases. A photocopy of this release is as effective as the original. This authorization will be valid for one year from the date signed unless specifically revoked in writing.

YOUR SIGNATURE Parent or Guardian, if applicant is a minor

Today's Date _____ Month _____ Day _____ Year _____