
CONDITIONS OF ENROLLMENT

By completing this application, I agree to the following:

1. I will read the Kaiser Permanente Senior Advantage *Evidence of Coverage (EOC)* to know which rules I must follow in order to receive coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente toll free at **1-800-509-7570** (TTY **1-800-659-2656**), seven days a week, from 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente Senior Advantage is a Medicare Advantage plan and has a contract with the Federal government.
3. I must maintain my enrollment in Medicare Part A and Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. 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 Senior Advantage plan as I can be enrolled in only one Senior Advantage plan at a time. My other employer or 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 trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.
6. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not 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.
8. 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 for more than 6 months in a row.
9. Enrollment in this plan is generally for the entire year.
10. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: November 15 – December 31 of every year), or under certain special circumstances, by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week.
11. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. Also, any services received under the Travel Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Kaiser Permanente Senior Advantage *EOC* for more information about covered benefits and services.
12. Once I become a member of Kaiser Permanente Senior Advantage, I have the right to appeal plan decisions about payment or services.
13. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be compensated based on my enrollment in Kaiser Permanente.
14. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

If you have health coverage from an employer or union/trust fund, joining Kaiser Permanente Senior Advantage may change how your current coverage works. Read the communications your employer or union/trust fund sends you. If you have questions, visit their Web site or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form

Important information about this application

PLEASE READ ALL PAGES BEFORE SIGNING THIS APPLICATION

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

- Completing and returning this application is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, please fill out this form for yourself and a separate one for your spouse. For assistance completing this application, please call **303-338-3814** (toll free **1-866-578-5527**) seven days a week, from 8 a.m. to 8 p.m. TTY users call **1-800-659-2656**.
- You are entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this application signifies that you have read, understand, and agree to these provisions. Kaiser Permanente is a Medicare Advantage organization with a Medicare contract.
- You will need to provide us with verification that you are entitled to Medicare Part A and enrolled in Medicare Part B and you must live inside our Kaiser Permanente Senior Advantage service area for us to enroll you. Please check the ZIP codes listed in the enclosed *Provider Directory* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
 - You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Colorado region, 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.
 - You belong to an employer group or trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE APPLICATION PROCESS

Submitting your application

- After completing pages 1–3 of this application, please read the sections titled “Release of Information” and “Conditions of Enrollment” at the end of this form. Then sign and date page 3.
- Please keep the bottom white copy of this application for your records. If required, send the middle yellow copy to your employer group or trust fund. Return the top, signed white copy in the enclosed postage paid envelope to:
 - Senior Advantage Sales Department**
 - Kaiser Permanente**
 - P.O. Box 378022**
 - Denver, CO 80237-9933**
- When we receive your application, we will screen it for completeness and signatures and we will then acknowledge receipt by mail.
- We will notify Medicare that you have applied to join Kaiser Permanente Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we will confirm the effective date of your coverage.
- We will then send you a Kaiser Permanente ID card and information for new members.

PLEASE COMPLETE THE INFORMATION BELOW


Last Name		First Name		Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Permanent residence street address (street address ONLY – no P.O. Box)					Apt. #
County		City		State	ZIP
Mailing address (if different from permanent residence)					Apt. #
County		City		State	ZIP
Daytime phone number		Evening phone number			Date of Birth
Social Security Number (SSN) – providing this information is optional			E-mail address – providing this information is optional		
Other contact: Name – providing this information is optional				Phone number	
Physician name				Physician ID#	
<i>Southern CO: Select a primary care physician. See enclosed Provider Directory or visit kp.org/medicalstaff.</i>					
Medical center name (if applicable)					

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 card or a copy of your Medicare verification letter that provides the same information.

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

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

For Individual Plan Applicants ONLY

PAYING YOUR PLAN PREMIUM

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 check. If you do not choose this option, we will send you a bill each month, which you can pay by mail, by Electronic Funds Transfer (EFT), or by credit card.

If you qualify for "extra help" with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Do you want Kaiser Permanente to bill you directly for your premium? Yes No

If you check "no," your premiums will be automatically deducted from your Social Security check.

The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

Note: We do not recommend Social Security deduction if you are getting extra help for your monthly plan premium payment from another payer. Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process.

ADDITIONAL INFORMATION

- Are you a current or former member of any Kaiser Permanente health plan? Yes No
If yes: Current Former Kaiser Permanente ID # _____
 - A) Do you currently have end-stage renal (kidney) disease? Yes No
B) Diagnosis date (MM/DD/YYYY) ____/____/_____
C) Transplant date (MM/DD/YYYY) ____/____/_____
- See the section titled "Important information about this application" on the cover page for additional information about enrolling with ESRD.

Last Name: _____ First Name: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If yes, please provide the following information:
 Date of admission (MM/DD/YYYY) ____/____/_____
 Name of Institution _____ Phone number _____
 Address _____ City _____ State ____ ZIP _____
4. Are you enrolled in your State Medicaid program (state-subsidized medical plan)? Yes No
 If yes, please provide your Medicaid number _____
5. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? Yes No
 If no, are you retired? Yes Retirement Date _____
 Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? Yes No
6. 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? 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 Applicants ONLY

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the Open Enrollment Period between January 1 and March 31 of each year. However, you cannot add or drop Medicare prescription drug coverage during this time. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box to the left of the statement(s) that apply to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled. We will contact you if we need additional information.

- I am new to Medicare.
- I recently moved outside of the service area of my current plan. Date of move _____
 Previous address _____
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I belong to a pharmacy assistance program provided by my state.
- I live in or recently moved out of a long-term care facility (such as a nursing home).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am either losing coverage I had from an employer or union/trust fund or leaving employer or union/trust fund coverage.
- I recently returned to the United States after living permanently outside of the U.S.
- I am currently enrolled in another Medicare Advantage plan.
- I am currently enrolled in a Medicare Part D Prescription Drug plan.
- None of these statements applies to me.*

* If none of the statements apply to you or if you are not sure, please contact Kaiser Permanente at 1-800-509-7570 (TTY users should call 1-800-659-2656) to see if you are eligible to enroll. We are open seven days a week, from 8 a.m. to 8 p.m.

Last Name: _____ First Name: _____

For Individual Plan Applicants ONLY

TYPE OF COVERAGE YOU ARE APPLYING FOR.

DENVER/BOULDER: Individual Plan coverage

Please select a specific plan: Core Silver Gold Plan premium _____
 Advantage Plus – optional supplemental benefits. Additional premium _____

You cannot enroll in Kaiser Permanente Senior Advantage if your current or former employer helps pay for your prescription drugs.

Senior Advantage Medicare Medicaid Plan (SNP) Plan premium _____

(Please note: Our Senior Advantage Medicare Medicaid Plan is available to Individual Plan members only. If you are a member of a Kaiser Permanente plan through your employer or [union/trust fund] and are interested in our Senior Advantage Medicare Medicaid Plan, you should call us to find out how to qualify for this plan.)

Requested effective date _____

SOUTHERN COLORADO: Individual Plan coverage

Please select a specific plan: Core Silver Plan premium _____
 Advantage Plus – optional supplemental benefits. Additional premium _____

You cannot enroll in Kaiser Permanente Senior Advantage if your current or former employer helps pay for your prescription drugs.

For Employer Group/Trust Fund Applicants ONLY

If you currently have Kaiser Permanente coverage through more than one employer or trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Trust Fund Name _____

Employer Group ID# _____ Subgroup _____ Requested effective date _____

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 is necessary for treatment, payment, and health care operations. I also acknowledge that Kaiser Permanente will release my information, including any 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 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 authorized representative _____ Date _____

Authorized representative name _____ Relationship _____
 (please print)

Address _____ Phone _____

Signature of any person who assisted in completing this form _____ Date _____

INTERNAL USE ONLY

Representative: _____ Language Pref _____

Denver/Boulder Medical Office: _____

Election type: ICEP AEP OEP OEPI OEPNEW SEP _____