KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive
Hyattsville, MD 20785

Individual and Family Plans

Account Change Form
Maryland

Instructions

- If you are an existing Kaiser Permanente for Individuals and Families (KPIF) member enrolled directly into a KPIF account, you may use this form to make plan changes or account changes. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- If you are an existing KPIF member enrolled through Maryland Health Connection, all account and plan changes to your existing coverage must be requested through marylandhealthconnection.gov. If you are not sure how you are enrolled or need additional support, please call **1-800-255-5169** (TTY **711**).
- There are different types of plan changes and account changes you can make with this form. Please fill out your personal information in Section A. Then select what changes you'd like to make in Section B, and continue on to fill out any other sections related to those changes.
- If you are a subscriber ending coverage, your dependents' coverage automatically ends. You may choose to keep your children under 21 years of age on a child-only account. If you're ending KPIF coverage because you are newly eligible for Group coverage or Medicare, your dependents have a Special Enrollment Period to enroll in new KPIF coverage. Go to **kp.org/specialenrollment** or contact Member Services to learn more.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. To avoid paying for 2 plans or having a gap in coverage, please cancel any other coverage they have as of the day before their new coverage starts.
- Eligible dependents include your Spouse or Domestic Partner, and you and your Spouse or Domestic Partner's eligible dependents who are under the age of 26.
- Note: If you're entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to change KPIF plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF plan as a new dependent.

A. Fill out your information

If you're making a change, please update the boxes below with your new information.

First name | MI | Date of birth (mm/dd/yyyy) / /

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female | Social Security number (if any) - -

Home address (no P.O. boxes)

City

State | ZIP code | County | Primary phone (mobile phone, if available) - -

Email address

Mailing address ☐ Check if same as home address

City

State | ZIP code

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

Please check the boxes below for the changes you wish to make, and on the next page, list each family member affected. We won't make any changes for any family members you don't list.

You can make the following changes only during open enrollment or a special enrollment period.
To make a change other than listed below, you can call Member Services at **1-800-777-7902.**

- ☐ Change plans.
- ☐ Add medical coverage for a family member.
- ☐ Add optional adult dental coverage (for members 19 and older).
- ☐ End optional adult dental coverage.
- ☐ Change my child-only account to a family account with myself as the subscriber.

(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

Combine KPIF Accounts

Accounts can be combined during open enrollment or a special enrollment period.

☐ I wish to add a family member(s) that is already on a KPIF plan to my account. Doing this will end their existing plan.
(Please indicate which family member(s) will move to your account in Section C.)

Account ending

First name | MI

Last name

Subscriber medical record number for account ending

X _____ Date (mm/dd/yyyy) __/__/____

Subscriber or parent/legal guardian for account ending

You can make the following changes any time during the year. *(Note: For these changes, you can skip Sections D and E.)*

- ☐ End all coverage for myself and all family members.
- ☐ End all coverage for a family member.
- ☐ End my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ End my and my spouse's/domestic partner's coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ Make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)

Requested effective date (not guaranteed)
__/__/____ (mm/dd/yyyy)

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

Spouse/Domestic partner

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Date of birth (mm/dd/yyyy) / / | Medical record number (if any)

Gender: ☐ Male ☐ Female | Social Security number (if any) - - | Primary phone (mobile phone, if available) - -

Email

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents. Provide phone and email for dependents aged 18 and over only.

Dependent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Date of birth (mm/dd/yyyy) / /

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email

(continues)

C. Which family members are affected by the change? (Please list below.) *(continued)*

Dependent 2

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female | Social Security number (if any)

Primary phone (mobile phone, if available)

Email

Dependent 3

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female | Social Security number (if any)

Primary phone (mobile phone, if available)

Email

D. Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Section E)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-255-5169** for more about qualifying life events or if you do not see your qualifying life event below.

Change in health coverage

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums
- ☐ Loss of pregnancy related coverage or loss of access to health care services through coverage provided to a pregnant woman's unborn child
- ☐ Loss of medically needy coverage
- ☐ Enrollment in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Being potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and being determined ineligible after open enrollment has ended or more than 60 days after the qualifying event
- ☐ Newly ineligible for Advanced Premium Tax Credit or newly ineligible for cost-sharing reductions

Change in household

- ☐ Gaining or becoming a dependent through marriage/domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
- ☐ Child support order or other court order to cover a dependent
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent

Change in residence

- ☐ Permanent relocation with access to new plans

Other qualifying life events

- ☐ Determination by Maryland Health Connection of a special enrollment period or when enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities
- ☐ Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee
- ☐ Initial confirmation of pregnancy by a health care practitioner

  Note: In this case, you also need to choose between 2 effective date options:

  - ☐ The first day of the month in which pregnancy is confirmed
  - ☐ The first day of the month in which we receive your completed form with your plan selection

Please write the date when your qualifying life event occurred. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Each family member you listed in Section C will be moved to 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 6700 Ded/Vision
- ☐ KP MD Bronze 7500 Ded/HSA/Vision
- ☐ KP MD Bronze Value 10150 Ded/Vision
- ☐ KP MD Silver 3000 Ded/700 RxDed/Vision
- ☐ KP MD Silver 6000 Ded/Vision/Off
- ☐ KP MD Silver Virtual Forward 3600 Ded/Off
- ☐ KP MD Silver Value 4500 Ded/750 RxDed/Vision/Off
- ☐ KP MD Silver Virtual Forward 5000 Ded
- ☐ KP MD Silver 4800 Ded/HSA/Vision
- ☐ KP MD Gold 0 Ded/150 RxDed/Vision
- ☐ KP MD Gold 500 Ded/Vision
- ☐ KP MD Gold 1100 Ded/200 RxDed/Vision
- ☐ KP MD Gold 1750 Ded/250 RxDed/Vision
- ☐ KP MD Gold Value 1000 Ded/150 RxDed/Vision
- ☐ KP MD Gold Plus 1750 Ded/Vision
- ☐ KP MD Gold 2400 Ded/HSA/Vision
- ☐ KP MD Platinum 0 Ded/Vision
- ☐ KP MD Catastrophic 10600 Ded/Vision*

*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're 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

F. Choose your optional adult dental plan

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

If you want to add optional adult dental coverage, please choose a dental plan:

- ☐ KP Smile KPIF Dental EPO
- ☐ KP Smile KPIF Dental PPO Basic
- ☐ KP Smile KPIF Dental PPO High
- ☐ KP Smile KPIF Dental EPO + Ortho
- ☐ KP Smile KPIF Dental PPO Basic + Ortho
- ☐ KP Smile KPIF Dental PPO High + Ortho

☐ No. I'm not interested in the optional adult dental coverage.

G. Sign the form

- I understand that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), will rely on the information provided in this form. I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B. I understand if I commit fraud or intentional misrepresentation of material fact, then 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 premiums 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 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.**
- I verify that no one listed on this form who is changing plans or being added as a dependent is entitled to Medicare Part A or enrolled in Medicare Part B.
- If I worked with a broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $18 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information visit **kaiserpermanente.org/termsconditions**.

Note: The subscriber making a change must sign the form.

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

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

Contact information

Mail to: Kaiser Permanente for Individuals and Families P.O. Box 23127 San Diego, CA 92193-9921	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-800-777-7902**

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille and accessible electronic formats

- Provides 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, 4000 Garden City Drive, Hyattsville, MD 20785, 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.

This notice is available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice

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HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, mbi èyɛm. Wɔ nàŋ **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)–এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** (TTY (تلفن متنی): **711**) تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ़्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください（TTY: **711**）。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902** 로 전화해 주세요(TTY: **711**).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) توجہ: اگر آپ اردو بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn iṣẹ́ ìrànlọ́wọ́ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).