KAISER PERMANENTE®

Individual and Family Plans

# Account Change Form

Colorado

## 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 Connect for Health Colorado, all account and plan changes to your existing coverage must be requested through connectforhealthco.com. 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.
- 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 ☐ Undeclared | 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

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Please check the boxes below for the changes you wish to make and 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 during open enrollment or a special enrollment period.** To make a change other than listed below, you can call Member Services at **1-800-632-9700** (TTY **711**).

- ☐ Change plans.
- ☐ Add medical coverage for a family member.
- ☐ 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/civil union 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.)
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)

Requested effective date (not guaranteed) ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

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

### Spouse/ civil union partner

☐ Name change ☐ Add medical coverage ☐ End medical coverage

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

First name | MI | Choose one: ☐ Spouse ☐ Civil union partner

Last name

Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) ☐☐☐-☐☐-☐☐☐☐

Medical record number (if any)

Primary phone (mobile phone, if available) ☐☐☐-☐☐☐-☐☐☐☐

Email address

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

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

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Primary phone (mobile phone, if available)

Email address

**Dependent 2**

☐ Name change ☐ Add medical coverage ☐ End medical coverage

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Primary phone (mobile phone, if available)

Email address

**Dependent 3**

☐ Name change ☐ Add medical coverage ☐ End medical coverage

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Primary phone (mobile phone, if available)

Email address

## 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 30 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-255-5169** (TTY **711**) 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 short-term health coverage

**Change in household**

- ☐ Gaining or becoming a dependent through marriage or civil union partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care

  **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Child support order or other court order to cover a dependent

  **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Losing a dependent through divorce, dissolution of a civil union 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 Connect for Health Colorado of exceptional circumstances
- ☐ Determination by Department of Insurance Commissioner of exceptional circumstances
- ☐ 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 after we receive the application
- ☐ Release from incarceration

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

*If you choose to have your coverage start on the first day of the month in which pregnancy is confirmed, you will be required to pay the monthly premiums retroactively for those additional months of coverage, and only services received in-network will be retroactively covered.

## 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. Choosing a health plan is based on your county. See the county list below to determine which health plans are available to you. 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. Your county may appear multiple times.

**Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park, and Teller**

**Plans available:**

- ☐ KP Select CO Bronze 6500/50
- ☐ KP Select CO Bronze 6500/35%/HSA
- ☐ KP Select CO Bronze 7500/60 RX Copay
- ☐ KP Select CO Bronze 8500/50
- ☐ KP Select CO Catastrophic*
- ☐ KP Select CO Silver 2500/30 X
- ☐ KP Select CO Silver 4500/35 RX Copay X
- ☐ KP Select CO Silver 3800/25%/HSA X
- ☐ KP Select CO Silver 4000/25 X
- ☐ KP Select CO Silver 5000/20%/HSA X
- ☐ KP Select CO Silver 5500/30 X
- ☐ KP Select CO Gold 0/25 RX Copay
- ☐ KP Select CO Gold 500/30/Dental/Vision
- ☐ KP Select CO Gold 1500/20
- ☐ KP Select CO Gold 2000/20
- ☐ KP Select CO Gold 3400/15%/HSA

**Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, and Weld**

**Plans available:**

- ☐ KP CO Bronze 6500/50
- ☐ KP CO Bronze 6500/35%/HSA
- ☐ KP CO Bronze 7500/60 RX Copay
- ☐ KP CO Bronze 8500/50
- ☐ KP CO Catastrophic*
- ☐ KP CO Silver 2500/30 X
- ☐ KP CO Silver 4500/35 RX Copay X
- ☐ KP CO Silver 3800/25%/HSA X
- ☐ KP CO Silver 4000/25 X
- ☐ KP CO Silver 5000/20%/HSA X
- ☐ KP CO Silver 5500/30 X
- ☐ KP CO Gold 0/25 RX Copay
- ☐ KP CO Gold 500/30/Dental/Vision
- ☐ KP CO Gold 1500/20
- ☐ KP CO Gold 2000/20
- ☐ KP CO Gold 3400/15%/HSA

**Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld**

**Plans available:**

- ☐ KP Colorado Option Bronze
- ☐ KP Colorado Option Silver X
- ☐ KP Colorado Option Gold

***For applicants under 30 or with hardship exemptions**

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

The Kaiser Permanente Catastrophic plan does not include pediatric dental benefits. If you are applying for this plan and have children under age 19 who will be covered, you must purchase pediatric dental coverage separately.

- ☐ I do not have children under age 19 who will be covered under this plan.
- ☐ I hereby attest that I have or will purchase pediatric dental essential health benefit (EHB) coverage.

**X** _____

Applicant's signature

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-632-9700** (TTY **711**), or contact your broker.

*(continues)*

## E. Choose your health plan *(continued)*

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. Sign the form

- If a broker has assisted you with this account/plan change, by signing below, you are giving permission to that broker to act on your behalf regarding this account/plan change.
- 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 $20 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- I understand that Kaiser Permanente will rely on the information provided in this form. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Permanente may choose to terminate coverage back to the coverage effective date.
- 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.
- 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 **healthy.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<br>P.O. Box 23127<br>San Diego, CA 92193 | **Or fax to:**<br>Membership Administration<br>**1-855-355-5334** | **Questions? Call**<br>**1-800-632-9700** (TTY **711**) |

All plans are offered and underwritten by Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247.

**NONDISCRIMINATION NOTICE**

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary 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 **1-800-632-9700** (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, ancestry, age, disability, sex,(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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**, (TTY **1-800-537-7697**). Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available at

https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice

---

**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 **1-800-632-9700** (TTY **711**).

**አማርኛ (Amharic) ትኩረት፦** አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** 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 **1-800-632-9700** (TTY **711**).

**Ɓăsɔ̀ɔ̀ Wùɖù (Bassa) Mbi sog:** nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yɛ́, mbi èyɛm. Wɔ nàŋ **1-800-632-9700** (TTY **711**)

**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 **1-800-632-9700**（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 **1-800-632-9700** (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 **1-800-632-9700** (TTY **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (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 **1-800-632-9700** (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。**1-800-632-9700** 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. **1-800-632-9700** 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, koji' hódíílnih **1-800-632-9700** (TTY **711**).

**नेपाली (Nepali) ध्यान दिनुहोस्:** यदि तपाइँ नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, नि:शुल्क उपलब्ध छन्। फोन **1-800-632-9700** (TTY: **711**).

**Afaan Oromoo (Oromo) XIYYEEFFANNOO:** Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (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 **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (TTY **711**).