KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
[4000 Garden City Drive, 5th Floor
Hyattsville, MD 20785]

Kaiser Permanente Insurance Company (KPIC)
[One Kaiser Plaza
Oakland, CA 94612]

Maryland
Virginia

Maryland and Virginia Small Group Employee Enrollment and Change Form HMO Plan and Flexible Choice Offerings

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS or Kaiser Permanente), and Kaiser Permanente Insurance Company (KPIC). We look forward to receiving your Enrollment and Change Form. **If you have any questions concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at [1-800-777-7902 or (TTY 711)] for those who are deaf, hard of hearing, or have speech impairment before signing this form.**

Please print. Use this form to enroll, waive, or change (add or delete) your family's membership status. To be a subscriber, you must live, work, or reside within our service area and you must be an employee who meets all of your employer's eligibility guidelines. **If you elect to waive coverage, you only need to complete Sections A and C.** If you have any questions, contact your employer's benefits office.

After you have completed this form, please sign and return it to your employer's benefits office. **Do not send this form to Kaiser Permanente unless otherwise instructed.**

If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at **[1-800-777-7902 or (TTY 711)]** for those who are deaf, hard of hearing, or have speech impairment for more information.

SECTION A: Employee Information

Please provide information about yourself in the relevant sections.

SECTION B: Benefit Plan Requested

Please provide information for the plan that you are selecting.

SECTION C: Waiver of Coverage

Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. Read and sign Section C.

SECTION D: Family Information

Dependent(s) or child(ren) dependent of domestic partner must meet your group's eligibility guidelines. If you have any questions on coverage, contact your employer's benefits office.

SECTION E: Other Coverage

Tell us if you, your spouse or domestic partner, if offered by your employer, or other family dependents or child(ren) dependent of domestic partner are covered by other health benefit plans. This may occur when both spouses or domestic partners are employed and have health care benefits from one or more health plan(s).

If you or your family are covered by more than one health benefit plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans.

If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS/KPIC to coordinate benefits with any health benefit plan that is determined to be the primary carrier, including, but not limited to, Medicare and Workers' Compensation, so long as you are enrolled in the primary plan and such plan remains primary to KFHP-MAS/KPIC plan. Your signature authorizes KFHP-MAS/KPIC and its employees to release any records or information with respect to any claim for covered services that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at **[1-800-777-7902 or (TTY 711)]** for those who are deaf, hard of hearing, or have speech impairment.

Maximum age/disabled dependent: Please complete this section to list any dependents or child(ren) dependent of domestic partner who exceed your employer's maximum limiting age requirements or are disabled. You will be requested to provide additional information to document dependents or child(ren) dependent of domestic partner who are indicated in this section.

Dependents residing at another PERMANENT address: Please use this section to document any dependents or child(ren) dependent of domestic partner who have a permanent address other than that of the subscriber (the Employee). You will be requested to provide additional information to document dependents or child(ren) dependent of domestic partner who are indicated in this section. This section does not apply to dependents or child(ren) dependent of domestic partner who are full-time students living in temporary housing while attending their classes.

SECTION F: Request for Enrollment or Cancellation

Review and sign this form. Before doing so, please make certain you have read all coverage materials. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card. If you are voluntarily electing to waive all insurance coverage offered by your employer, please only complete sections A and C.

SECTION G: Employer Authorized Representative Signature

To be completed by employer.

MISREPRESENTATION: KFHP-MAS/KPIC may deny insurance benefits if false information materially related to a claim was knowingly or willfully provided by the applicant.

KAISER PERMANENTE®

Maryland
Virginia

Company name: | Effective Date:[1] | Date of qualifying event: | Group number:

New Enrollment Self Only Self and Dependent(s) or child(ren) dependent of domestic partner Open Enrollment New Hire	Qualifying Life Event COBRA Rehire / Reinstatement Waiver Other	Change of Coverage Add Spouse or Domestic Partner[2] Add Dependent Child[2] or child(ren) dependent of domestic partner Name Change[2] Other	Employee Termination Remove Spouse or Domestic Partner[2] Remove Dependent Child[2] or child(ren) dependent of domestic partner Cancel Coverage

[1] Consult your employer for the effective date.
[2] Additional information may be requested.

SECTION A: Employee Information

Must be completed by the employee.

Employee Last Name: | First Name: | MI: | Suffix:

Social Security Number: | Date of Birth: | Male: | Female:

Address: | Unit #:

City: | State: | Zip Code:

Mobile Phone (required): | Work Phone: | Email:

Have you or any dependents or child(ren) dependent of domestic partner requesting coverage ever been covered as a member of KFHP-MAS or KPIC?
Yes No

Check One:
Full Time Part Time 1099 Contractor

If you do not physically work at your employer's address, please provide your primary working address:

SECTION B: Benefit Plan Requested

Enter only one group health plan as provided by your employer (which includes pediatric dental essential health benefits).
Medical plan selected:

Dental Enhancement (Optional): **Employer-Selected Adult Dental Rider (and cosmetic orthodontic plan where offered by your employer)**
Dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan.

Benefits underwritten by KFHP-MAS: The [HMO], [Kaiser Permanente Plus], [Deductible HMO], [Deductible Kaiser Permanente Plus], [Added Choice], [Qualified Health Savings Account (HSA) HDHP], [Flexible Choice (Option 1 HMO)], and [HSA-Qualified Flexible Choice (Option 1 HDHP)].

Benefits underwritten by KPIC: The [Flexible Choice (Option 2 PPO & Option 3 Out-of-Network)] and [HSA-Qualified Flexible Choice (Option 2 PPO & Option 3 Out-of-Network)].

The employer retains sole discretion whether to open and contribute, and how much to contribute, to a Health Savings Account (HSA) for employees who enroll in certain plans.

KAISER PERMANENTE®

Maryland
Virginia

SECTION C: Waiver of Coverage

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

All coverage
Coverage for my spouse or domestic partner
Coverage for my child(ren) or child(ren) dependent of domestic partner

I understand that if I or my dependents or child(ren) dependent of domestic partner later wish to enroll for any of the coverage(s) refused, I/they will be required to submit documentation to support enrollment outside the Open Enrollment period and coverage may be subject to late enrollment provisions as allowed by law and as directed by my employer.

Reason for Refusal:

Other group coverage sponsored by my spouse's or domestic partner's employer[1]
Other group coverage sponsored by another organization[1]
Medicare/Medicaid/TRICARE[1]
Individual coverage[1]
Parental coverage (must be under 26 or disabled)[1]
Other reasons (please explain)

Waiving Employee Signature:

Date:

[1] Additional information may be requested.

SECTION D: Family Information

Must be completed by the employee.
If additional space is needed, please use another form and attach to this form.

Spouse or Domestic Partner *(if eligible under your plan)* Last Name: | First name: | MI: | Suffix:

Social Security Number: | Date of birth: | Male: Female: | Relationship to Employee: | Mobile Phone (required)

Child's Last Name: | First name: | MI: | Suffix:

Social Security Number: | Date of birth: | Male: Female: | Relationship to Employee:

Child's Last Name: | First name: | MI: | Suffix:

Social Security Number: | Date of birth: | Male: Female: | Relationship to Employee:

Child's Last Name: | First name: | MI: | Suffix:

Social Security Number: | Date of birth: | Male: Female: | Relationship to Employee:

Child's Last Name: | First name: | MI: | Suffix:

Social Security Number: | Date of birth: | Male: Female: | Relationship to Employee:

SECTION D: Family Information *(continued)*

Are any of your listed dependents or child(ren) dependent of domestic partner over the Group's maximum age(s)?
If yes, please complete the following.

Name(s) (Last, First, MI)	Disabled[1]	Reason
	Yes No	
	Yes No	

Do any of your dependents or child(ren) dependent of domestic partner above permanently reside at another address?
Yes No
If yes, please complete the following. If additional space is needed, please use another form and attach to this form.

Last Name: First Name: MI: Suffix:

Address: Unit #:

City: State: Zip Code:

[1] Additional information may be requested.

SECTION E: Other Coverage

Including yourself, do any of the persons listed above have other health coverage? Yes No **If yes, please list below.**

Name	Insurance Carrier Name	Policy Number	Telephone Number

Are you or any of your dependents or child(ren) dependent of domestic partner eligible for Medicare? Yes No

KAISER PERMANENTE®

Maryland
Virginia

SECTION F: Request for Enrollment or Cancellation[1]

Request for Enrollment

I hereby apply, on behalf of myself and each dependent or child(ren) dependent of domestic partner listed above, for the health coverage indicated. If this form is accepted, coverage will be provided according to the terms and conditions of my employer's contract with KFHP-MAS/KPIC. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay required subscription charges to my employer.

Request for Cancellation

I hereby request on behalf of myself and each dependent or child(ren) dependent of domestic partner listed above, that my coverage be canceled.

Remove spouse or domestic partner
Remove dependent child(ren) or child(ren) dependent of domestic partner– Name(s):
Cancel entire coverage

If you have any questions concerning the benefits and services that are to be provided by or excluded under the coverage that is the subject of this enrollment form, please contact a Member Services representative before signing this enrollment form at [1-800-777-7902 or (TTY 711)] for those who are deaf, hard of hearing, or have speech impairment.

I authorize KFHP-MAS/KPIC and its employees to release any records or information with respect to any claim for covered services that may be requested by another insurance carrier. Such authorization shall be valid for the duration of coverage.

I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete, and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

Employee Signature: **Date:**

[1] Consult your employer for the effective date.

Enrollees from the following states are to refer to their specific state warning:

Maryland: 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.

Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

If you have any questions concerning the benefits and services that are to be provided by or excluded under the coverage that is the subject of this enrollment form, please contact a membership services representative before signing this enrollment form.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete, and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

SECTION G: Employer Authorized Representative Signature

I hereby certify that this (these) enrollment(s) has (have) been reviewed and meet(s) all eligibility requirements.

Printed or Typed Name:

Title: **Phone Number:**

Employer Signature: **Date:**