KAISER PERMANENTE
Senior Advantage

ELECTION FORM
Employer Group Plan

Important information about this election form

PLEASE READ ALL PAGES BEFORE SIGNING THIS ELECTION FORM.

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

- Completing and returning this election form 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 election form, please contact the Kaiser Permanente Member Service Call Center toll free at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing or speech impaired) seven days a week, from 8 a.m. to 8 p.m.
- You are entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this election form 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 *Evidence of Coverage* 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, 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.

If you have health coverage from an employer or trust fund, joining Kaiser Permanente Senior Advantage may change how your current coverage works. Read the communications your employer or trust fund sends you. If you have questions, visit their website, 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.

ABOUT THE APPLICATION PROCESS

Submitting your election form

- After completing pages 1–3 of this election form, please read the sections titled "Kaiser Foundation Health Plan Arbitration Agreement," "Release of Information," and "Conditions of Election" at the end of this form. Then sign and date page 3.
- Please keep the pink copy of this election form for your records. If required, send the bottom white copy to your employer group or trust fund. Return the top, signed white copy to:

  California Service Center
  P.O. Box 232400
  San Diego, CA 92193-2400

- When we receive your election form, 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.
- You may receive a Kaiser Permanente ID card and information for new members.

ELECTION FORM

Page 1 of 3 for applicant to complete

PLEASE COMPLETE THE INFORMATION BELOW

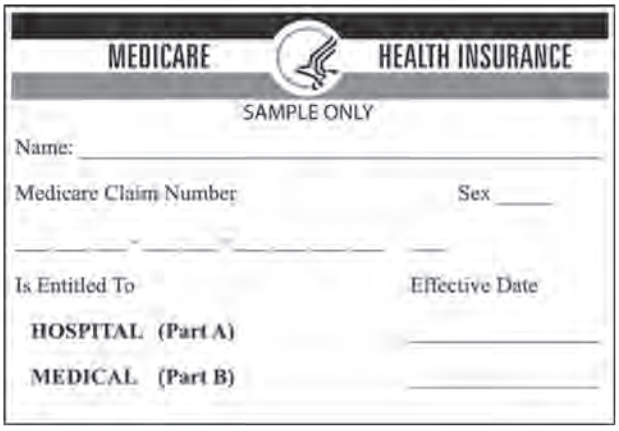
Last Name	First Name	Middle Initial	Sex ☐ M ☐ F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt. #
County	City	State	Zip
Mailing address (if different from permanent residence)			Apt. #
County	City	State	Zip
Daytime phone number	Evening phone number		Date of Birth
Social 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	

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 verification letter (Letter of Award from the Social Security Administration or Railroad Retirement Board) 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) _____

Employer group/trust fund name _____

Employer group ID # _____ Requested Effective Date _____

ELECTION FORM Page 2 of 3 for applicant to complete

Last Name: _____ First Name: _____

ADDITIONAL INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? ☐ yes ☐ no

   If yes: Current ☐ Former ☐ Kaiser Permanente ID # _____

2. 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 election form" on the cover page for additional information about enrolling with ESRD.

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 Medi-Cal (state-subsidized medical plan)? ☐ yes ☐ no

   If yes, please provide your Medi-Cal number _____

5. Do you or your spouse work? ☐ 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: _____

ELECTION FORM Page 3 of 3 for applicant to complete

Last Name: _____ First Name: _____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

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 election 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 by law _____ Date _____

Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

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

INTERNAL USE ONLY

Date Stamp _____ Language Preference _____ Rep's Name _____

Election type: ☐ ICEP ☐ AEP ☐ OEP ☐ OEPI ☐ OEPNEW ☐ SEP _____

CONDITIONS OF ELECTION

By completing this election form, I agree to the following:

1. I will read the Kaiser Permanente Senior Advantage *Evidence of Coverage* when I receive it to know which rules I must follow in order to receive coverage in this Medicare Advantage plan.
2. I understand that Kaiser Permanente Senior Advantage is a Medicare Advantage plan and I must maintain my enrollment in Medicare Part A and Part B insurance.
3. 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.
4. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
5. 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.
6. 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.
7. Enrollment in this plan is generally for the entire year.
8. I may leave this plan only at certain times of the 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.
9. I understand that starting on the effective date of my coverage, I must receive all of my medical care from Kaiser Permanente, except for emergency care, out-of-area urgent care, or dialysis care while temporarily outside the service area, or authorized referrals. Neither Medicare nor Kaiser Permanente will pay for doctor or hospital care received from non–Kaiser Permanente physicians/facilities (non-Plan providers), except for emergency care, out-of-area urgent care, or dialysis care while temporarily outside the service area, or authorized referrals.
10. Once I become a member of Kaiser Permanente Senior Advantage, I have the right to appeal plan decisions about payment or services.
11. If I am a Medicare Cost member enrolling in Senior Advantage, I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot re-enroll in the Medicare Cost plan.

RETURN FORM TO:

California Service Center
P.O. Box 232400
San Diego, CA 92193-2400