KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Kaiser Foundation Health Plan of Washington

Instructions

- 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're adding a dependent to your plan, any other coverage they have won't be automatically canceled. 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 Kaiser Foundation Health Plan of Washington (KFHPWA) plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KFHPWA plans or be added to your KFHPWA plan as a new dependent.

A. Fill out your information

Please select one: I'm the ☐ subscriber, ☐ spouse/domestic partner, or dependent child 18 and older, or ☐ parent or legal guardian
If you're making a change, please update the boxes below with your new information.

First name

MI

Gender: ☐ Male ☐ Female

Last name

Date of birth (mm/dd/yyyy) / /

Medical record number (if any)

Social Security number (if any) - -

Phone - -

Home address (no P.O. boxes, please)

City

State

ZIP code

Mailing address ☐ Check if the same as the 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 on the next page, list each family member affected. We won't make any changes for any family members you don't list.
- The subscriber (or parent or legal guardian for subscribers under 18) can make all the changes below for any family members. Dependents 18 and older can make changes for themselves for items marked with an asterisk (*) below.

You can make the following changes during open enrollment or a special enrollment period.
(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

- ☐ I wish to change plans.*
- ☐ I wish to combine accounts.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to add medical coverage for myself on my family's account as the subscriber.
- ☐ I wish to add adult/family dental coverage for all members on this account.*
- ☐ I wish to add pediatric dental coverage (for members 18 and younger).

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

- ☐ I'm ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.*
- ☐ I wish to change the subscriber.
- ☐ I wish to change the parent/legal guardian on a child-only account.
- ☐ I wish to end medical coverage for myself* or for a family member.
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.
- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ I wish to 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.)*
- ☐ I wish to end my/our adult/family dental coverage (everyone's coverage will be canceled).*
- ☐ I wish to end pediatric dental coverage for my dependent(s) 18 and younger.

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

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

Spouse/Domestic partner

☐ Add medical coverage ☐ End medical coverage
☐ Add adult dental coverage ☐ End adult dental coverage
☐ Add pediatric dental coverage ☐ End pediatric dental coverage

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

Social Security number (if any) ☐☐☐-☐☐-☐☐☐☐ | Medical record number (if any) | Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ | Gender: ☐ Male ☐ Female

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

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

If you have more than 4 dependents with a change, attach a copy of this page and complete the information for those dependents.

Dependent 1

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___-___-___ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __/__/____

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

Dependent 2

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___-___-___ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __/__/____

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

Dependent 3

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___-___-___ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __/__/____

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

Dependent 4

☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) ___-___-___ | Medical record number (if any) | Date of birth (mm/dd/yyyy) __/__/____

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

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.** Visit **kp.org/specialenrollment** or call **1-800-290-8900** for more about qualifying life events.

☐ Loss of minimum essential health coverage (write the last full day you had coverage)*

Did you lose coverage with us (KFHPWA) that was provided by your employer?

☐ Yes ☐ No

If Yes, you have 2 options for continuing your coverage with us.

- ☐ Coverage that begins automatically the day after your employer coverage ends.
- ☐ Coverage that begins based on when we receive your application. Please see **kp.org/specialenrollment** under "Loss of minimum essential health coverage" for more details.

☐ Gaining or becoming a dependent through marriage or domestic 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 gaining the dependent

☐ 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

☐ Permanent relocation with access to new plans

☐ Changes in employer health coverage making you eligible for a premium tax credit

☐ Determination by Washington Healthplanfinder of exceptional circumstances

☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)

☐ Domestic violence or spousal abandonment occurring within the household

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

*If your qualifying life event is loss of KFHPWA coverage, we may review membership records to check when and why you lost coverage. For more about minimum essential coverage, visit **kp.org/specialenrollment**.

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.

CoreSelect Network

- ☐ Bronze
- ☐ Bronze HSA*
- ☐ Flex Bronze
- ☐ Silver HSA*
- ☐ Flex Silver HD
- ☐ Flex Gold

Connect Network

Available in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties

- ☐ Virtual Plus Bronze

*HealthEquity administers a health savings account (HSA) that's integrated with your KFHPWA medical plan.

Do you want to choose HealthEquity for your HSA? ☐ Yes ☐ No

F. Choose your dental plan

If you want to add dental coverage, please choose your dental plan:

- ☐ Pediatric Dental #09140
- ☐ Adult/Family Dental #09145

G. Sign the form

- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- 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.

Note: The subscriber and all dependents 18 and older making a change must sign the form. If there are more than 4 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

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

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

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

Spouse/domestic partner

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

Dependent (18 and older)

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

Dependent (18 and older)

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

Dependent (18 and older)

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

Dependent (18 and older)

Contact information

Mail to: Kaiser Foundation Health Plan of Washington Membership Administration P.O. Box 34750 Seattle, WA 98124-1750	**Or fax toll free to:** Membership Administration **206-630-7001**	**Questions? Call** **1-800-290-8900** (TTY **711**)

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington, 601 Union St., Suite 3100, Seattle, WA 98101.

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ **(Khmer)**៖ របយ័ត៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរអក។ ចូរទូ រស័ព

1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (Japanese): 注意事項：日本語を話される場 合、無料の言語支援をご利用いただけます。 1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (*መስማት ለተሳናቸው*: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (711 / 1-800-833-6388) .

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.