

Advantage Plus Enrollment Form

California Region

Thank you for your interest in our Advantage Plus plan. Combining the benefits of Advantage Plus with your Kaiser Permanente Senior Advantage (HMO) plan can enhance your health and well-being. Please read all pages of this enrollment form carefully before signing.

Enrollment periods

The Advantage Plus optional supplemental benefits package is **only** available to members who are enrolled in or have recently applied for a Kaiser Permanente Senior Advantage Individual Plan.

- **New Senior Advantage member:** If you are a new Senior Advantage member, you can add Advantage Plus within 30 days of your Senior Advantage effective date.
- **Existing Senior Advantage member:** If you already have Senior Advantage, you can sign up for Advantage Plus from October 15, 2020, until March 31, 2021 (your enrollment form must be received in our office by this date).

How to enroll in Advantage Plus



Online: You can complete the entire enrollment process online.
Enrolling is fast and easy at kp.org/advantageplus.



Mail: To enroll by mail, complete and mail pages 2 and 3 of this form.

Please keep a copy of this form for your records. Do not send cash or check. You will be billed.

If you have questions, please call us at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

Return the signed form to: Kaiser Permanente
Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400



Important information: Print in CAPITAL LETTERS and use blue or black ink only. Fill in check boxes with an "X" to mark your responses.

A. Plan benefits

The Advantage Plus supplemental benefits package includes dental, hearing, and extra vision coverage for **\$16** per month. A **\$16** monthly premium for Advantage Plus benefits will be added to your Kaiser Permanente Medicare health plan monthly premium. (Not available under the Senior Advantage Medicare Medi-Cal (HMO D-SNP) plans.)

B. Subscriber information

Last name

[Grid for last name]

First name

[Grid for first name]

MI

[Grid for MI]

Gender

Male

Female

Kaiser Permanente medical/health record #

[Grid for Kaiser Permanente medical/health record #]

Medicare number (found on your Medicare card)

[Grid for Medicare number]

Home phone number

[Grid for home phone number]

Mobile phone number

[Grid for mobile phone number]

Date of birth (mm/dd/yyyy)

[Grid for date of birth]

Permanent residence street address (P.O. box is not allowed)

[Grid for permanent residence street address]

City

[Grid for city]

State

[Grid for state]

ZIP code

[Grid for ZIP code]

Mailing address, if different from permanent residence (P.O. box is OK)

[Grid for mailing address]

City

[Grid for city]

State

[Grid for state]

ZIP code

[Grid for ZIP code]

Email address

[Grid for email address]

Subscriber name

[Grid for subscriber name]

C. Conditions of enrollment

By completing this application form:

- I agree to adding the Advantage Plus optional supplemental benefits package that gives me dental, hearing, and extra vision coverage for \$16 per month...
I understand that the Advantage Plus optional supplemental benefits package is only available to members enrolled in a Kaiser Permanente Senior Advantage Individual Plan.
I understand that I must get covered care from network providers, except for emergency or urgently needed services.
I understand that the dental, hearing, and extra vision coverage supplements my Senior Advantage coverage and is subject to the terms and conditions stated in the Kaiser Permanente Senior Advantage Evidence of Coverage.
I understand that I can disenroll from Advantage Plus coverage at any time. If I disenroll, I will not be eligible to enroll until the next Advantage Plus annual election period for coverage effective January 1, 2022.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application (including the "Conditions of enrollment" section above). 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.

Signature

[Signature line]

Today's date (mm/dd/yyyy)

[Date grid]

If you are the authorized representative, you must sign above and provide the following information:

Name

[Name grid]

Address

[Address grid]

City

[City grid]

State

[State grid]

ZIP code

[ZIP code grid]

Phone number

[Phone number grid]

Relationship to member

[Relationship to member grid]

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide 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, and accessible electronic formats.
- Provide 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 Member Services at **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

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, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. 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>.

Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: 711).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-443-0815** (TTY: 711).

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 **1-800-443-0815** (TTY: 711)。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-443-0815** (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-443-0815 (TTY: 711)번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք **1-800-443-0815** (TTY (հեռատիպ) 711):

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: 711).

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。**1-800-443-0815** (TTY:711) まで、お電話にてご連絡ください。

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-800-443-0815 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ
ក៏អាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815** (TTY: 711)។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau **1-800-443-0815** (TTY: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-443-0815 (TTY: 711) पर कॉल करें।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-0815**
(TTY: 711).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می
باشد. با **1-800-443-0815** (TTY: 711) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -
5180-344-008-1 (رقم هاتف الصم والبكم: 117).