KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Grandfathered
Colorado

Instructions

- You may use this form to make plan changes or account changes to an existing Kaiser Permanente for Individuals and Families (KPIF) account. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- 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 and select the date you'd like your plan or account change to take effect (effective dates are not guaranteed). Then select what changes you'd like to make in Section B.
- If you are a subscriber ending coverage, your dependents' coverage automatically ends, and they have a special enrollment period to enroll in new coverage.
- 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, please)

City

State | ZIP code

Phone (mobile phone if available) ___ - ___ - ____

Mailing address ☐ Check if same as home address

City

State | ZIP code

Requested future effective date
(date must be the 1st of the month) __ __ / 0 1 / __ __ __ __

Email address

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

Subscribers (including the parent or legal guardian of child-only accounts) can make all the changes below for any family members. To make a change other than listed below, you can call Member Services at **1-800-632-9700** (TTY **711**).

- ☐ I wish to end all coverage for myself and all family members.
- ☐ I wish to end all coverage for a family member.
- ☐ I wish to change plans. (Please see the plan change rules on page 3, then select the plan you want to change to based on those restrictions.)
- ☐ I wish to add medical coverage for a newborn or newly adopted child.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)

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

If you have more than 2 dependents with a change, attach a copy of this page and complete the information for those dependents.

Spouse/civil union partner

☐ Name change ☐ End medical coverage

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)

Phone (mobile phone if available)

Dependent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage

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)

Phone (mobile phone if available)

Dependent 2

☐ Name change ☐ Add medical coverage ☐ End medical coverage

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)

Phone (mobile phone if available)

D. Choose your health plan

- If you want to change your coverage to a different grandfathered plan, you can only change to a plan that has equal or lesser benefits. According to the list to the right, this means you can only change to a plan listed **below** your current plan. With this in mind, please check the box next to the plan you'd like to change to. All active family members on your account will be moved to this plan.

Note: You won't be able to change back to your previous plan once 30 days have passed from your new grandfathered plan's effective date.

- ☐ $40 Copayment Plan with Rx
- ☐ $1,000 Deductible Plan (80%) with Rx
- ☐ $2,000 HSA-Qualified Deductible HMO Plan (100%)
- ☐ $1,500 Deductible Plan (80%) with RX
- ☐ $2,500 HSA-Qualified Deductible HMO Plan (100%)
- ☐ $2,000 Deductible Plan (70%) with Rx
- ☐ $3,000 HSA-Qualified Deductible HMO Plan (100%)
- ☐ $2,000 HSA-Qualified Deductible HMO Plan (80%)
- ☐ $2,000 Deductible Plan (70%)
- ☐ $3,000 Deductible Plan (70%) with RX
- ☐ $5,000 Deductible Plan (60%) with RX (Children's Plan)
- ☐ $4,000 HSA-Qualified Deductible HMO Plan (100%)
- ☐ $5,000 Deductible Plan (70%)
- ☐ $5,000 HSA-Qualified Deductible HMO Plan (100%)

E. Sign the form

- I understand that Kaiser Permanente will rely on the information I provide in this form, and that if any information is found to be fraudulent or intentionally misrepresented, Kaiser Permanente may choose to terminate my coverage back to the coverage effective date. 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 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 mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.
- 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 $18 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

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 P.O. Box 23127 San Diego, CA 92193	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call** **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 civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan 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 **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, age, disability, or sex, 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**.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY **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 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **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。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY **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 **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

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NOTES

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