KAISER PERMANENTE®

5011099602

Individual and Family Plans

Account Change Form

Maryland

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 Permanente for Individuals and Families (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

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

Billing address ☐ Check if the same as the home address.

City

State

ZIP code

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 can make some of the changes – those marked with an asterisk (*) below – only for themselves.

You can make the following changes only 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 optional enhanced adult dental coverage (for members 19 and older).*
- ☐ I wish to add medical coverage for myself on my family's account as the subscriber.

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.)*
- ☐ I wish to end optional enhanced adult dental coverage.*

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

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

Spouse/domestic partner

☐ Add medical coverage
☐ End medical coverage
☐ Add adult optional enhanced dental coverage
☐ End optional enhanced adult 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

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 optional enhanced dental coverage ☐ End optional enhanced adult 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) __/__/____

Dependent 2

☐ Add medical coverage ☐ End medical coverage ☐ Add adult optional enhanced dental coverage ☐ End optional enhanced adult 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) __/__/____

Dependent 3

☐ Add medical coverage ☐ End medical coverage ☐ Add adult optional enhanced dental coverage ☐ End optional enhanced adult 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) __/__/____

Dependent 4

☐ Add medical coverage ☐ End medical coverage ☐ Add adult optional enhanced dental coverage ☐ End optional enhanced adult 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) __/__/____

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 **1-800-494-5314** for more about qualifying life events.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage/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
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a 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 ineligible for a premium tax credit or change in eligibility for cost-sharing reductions
- ☐ Determination by Maryland Health Connection of a special enrollment period or when enrollment or nonenrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities
- ☐ 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
- ☐ Initial confirmation of pregnancy by a health care practitioner

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

*If your qualifying life event is loss of Kaiser Permanente 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.

- ☐ KP MD Bronze Value 6000/55/Vision
- ☐ KP MD Bronze 7500/40%/Vision
- ☐ KP MD Bronze 6900/0%/HSA/Vision
- ☐ KP MD Silver Value 2500/35/Vision/Off
- ☐ KP MD Silver 6000/40/Vision/Off
- ☐ KP MD Silver 3200/20%/HSA/Vision/Off
- ☐ KP MD Gold Value 0/20/Vision
- ☐ KP MD Gold Value 1000/20/Vision
- ☐ KP MD Gold 1750/20/Vision
- ☐ KP MD Platinum 0/15/Vision
- ☐ KP MD Catastrophic 8550/0/Vision*

*To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your account change without the certificate of exemption if you're 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

F. Enhanced dental HMO rider

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

- ☐ Yes. I would like to enhance my dental coverage by selecting a Dental HMO Rider for each member age 19 and older who is applying for medical coverage.
- ☐ No. I'm not interested in the optional adult dental coverage.

G. Sign the form

- I understand that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), will rely on the information provided in this form. I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B. I understand if I commit fraud or intentional misrepresentation of material fact, then Health Plan may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premiums paid, I agree to be responsible to Health Plan for the difference.
- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 1-800-777-7902 before signing this application.**
- **WARNING: 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.**
- 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: Employer Services Dept./KPIF 5W Kaiser Permanente for Individuals and Families 2101 E. Jefferson St. Rockville, MD 20852-9995	**Or fax toll-free to:** Membership Administration **1-855-414-2796**	**Questions? Call** **1-800-777-7902**

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (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 **1-800-777-7902** (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 or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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, 1-800-537-7697 (TDD). Complaint forms are available at http://www.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 **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓǎsɔ́ɔ̀ 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 bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (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。**1-800-777-7902**（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. **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-800-777-7902** (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 **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

KAISER PERMANENTE®