ELECTION FORM

Important information about this election form

PLEASE READ ALL PAGES BEFORE COMPLETING AND SIGNING THIS 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 applying, please complete one form per person. If your name and address information is pre-printed, review it carefully and make any necessary corrections. For assistance completing this application, please call **1-877-882-2687** (TTY **1-800-777-1370**), Monday through Friday (except holidays), from 8 a.m. to 5:30 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.

- You will need verification that you are entitled to Medicare Part A and enrolled in Medicare Part B and **you must live in a Kaiser Permanente Senior Advantage service area to enroll.**

  To be sure you qualify for enrollment, please refer to the Kaiser Permanente Senior Advantage *Group Disclosure Form (DF)* and/or *Evidence of Coverage (EOC)*.These documents can be found in the enrollment kit, which you can request from your employer Group benefits administrator, or by calling our Senior Advantage enrollment specialists at **1-877-822-2687** (TTY **1-800-777-1370**), Monday through Friday (except holidays), from 8 a.m to 5:30 pm.

- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is true:
  - Your date of diagnosis was while you were already a Kaiser Permanente member
  - You were in a Medicare Advantage (or Medicare+Choice) care 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

About the application process

After completing this election form, please read the sections entitled Conditions of Election and Arbitration Agreement and Authorization to Exchange Information at the end of this form, and then sign and date page 3. **Keep the pink copy of this election form for your records.** If required, send the bottom white copy to your Employer Group. Return the top signed white copy to:

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

- Once we receive your application, we screen it for completeness and signature and we then acknowledge receipt by mail.

- We notify Medicare that you have applied to join Kaiser Permanente Senior Advantage.

- Within seven days after Medicare confirms your eligibility, we will confirm the effective date of your coverage.

- We will then send you a Kaiser Permanente ID card and information for new members.

Conditions of Election

Please read the following statements before you sign this form:

If you are electing Kaiser Permanente Senior Advantage coverage, be certain that you fully understand the arbitration provision, benefits, limitations and conditions which are described in the *Group Disclosure Form (Group DF)* and/or *Evidence of Coverage (EOC)*. The above documents can be found in the enrollment kit, and it is available through your Group benefits administrator or made available by calling our Senior Advantage enrollment specialists toll free at **1-877-882-2687** (TTY **1-800-777-1370**), Monday through Friday (except holidays), from 8 a.m. to 5:30 p.m.

- I will abide by Health Plan policies and rules that apply to me.
- I understand that I cannot belong to another Medicare Advantage plan or Medicare Advantage Prescription Drug Plan and Kaiser Permanente Senior Advantage at the same time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan in which I am currently a member.
- I understand that I can be a member of only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. I cannot enroll in more than one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan with the same effective date. If I do so, the enrollment form with the latest signature date will be processed by the Centers for Medicare & Medicaid Services (CMS). It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- I have read and understand the limitations and exclusions of Senior Advantage coverage contained in the Senior Advantage *Group DF* and/or *EOC*.
- I understand that I must maintain my enrollment in Medicare Part A and Part B insurance.
- I understand that I will be notified by mail of the effective date of my Senior Advantage coverage. The effective date of my coverage will be determined by the date Health Plan receives my completed Senior Advantage Election Form. I understand that there are exceptions to these rules, as described in the *Group DF* and/or *EOC*. I also understand that I should not disenroll from any Medicare supplemental plan or Medigap/ Medicare Select plan until I receive confirmation from the Medicare Advantage plan.
- I understand that I must enroll in the Kaiser Permanente Senior Advantage service area in which I reside. It is my obligation to notify Kaiser Permanente if I permanently move or leave the service area and that my absence means that Kaiser Permanente may take action to disenroll me. I also understand that if I move from one California Kaiser Permanente Senior Advantage service area to another, I must complete a new election form, and that benefits, copayments and dues may differ.
- I understand that I may disenroll from Senior Advantage membership by submitting a written request to Kaiser Permanente, a Social Security office, or the Railroad Retirement Board (if a Railroad Annuitant). The date of my disenrollment will be determined by the date the written request is received by Health Plan and is verified by CMS. I understand that there are exceptions to these rules, as described in the *Group DF* and/or *EOC*.
- If I am a Medicare Cost member, I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot enroll or re-enroll in this plan.
- I understand that I must receive all of my medical care from Kaiser Permanente from the effective date of my coverage, except for emergency or urgently needed care or out-of-area dialysis services. Neither Medicare nor Kaiser Permanente will pay for doctor or hospital care received from non-Kaiser Permanente physicians or facilities. The exceptions to this are for emergency care, urgent care, or dialysis care while temporarily outside the service area, or authorized referrals. The definitions of those terms are in the *Group DF* and/or *EOC*, which I have received. I have read and understand those definitions.
- I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the Plan.

Please read carefully before you sign this form.

Employer Group Plan with Part D

To enroll in Kaiser Permanente Senior Advantage, please provide the following information.

Requested Effective Date ______________________________

Last Name			First Name	Middle Initial
Permanent Residence (Street Address ONLY — No P.O. Box)				
City	State	ZIP Code	County of Residence	
Mailing Address if different from Permanent Residence				
City	State	ZIP Code	Daytime Phone	Evening Phone

Sex: ☐ Male ☐ Female Date of birth ______/______/__________

Social Security number (providing this information is optional) _________-_________-_________

Are you currently a member of any Kaiser Permanente health plan, including through your employer or former employer? ☐ yes ☐ no

Were you a member of any Kaiser Permanente health plan in the past? ☐ yes ☐ no

If you answered yes to either of the previous two questions, please provide your

Kaiser Permanente Medical Record Number (MRN) ______________________________

and if applicable, please provide your

Employer Group name ______________________ Group ID # ______________________

Please answer the following questions (the information you provide will not be used for health screening purposes).

1. Are you the employee/retiree? ☐ yes ☐ no

   If you are the retiree, retirement date (month/date/year) ______/______/__________

2. Are you covering a spouse or dependents under this employer plan? ☐ yes ☐ no

   If yes, name of spouse: ______________________________

   Name of dependents: ______________________________

3. Do you or your spouse work? ☐ yes ☐ no

4. Some individuals may have other drug coverage, including other private insurance, Worker's 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 Coverage ______________

Employer Group Plan with Part D

Last Name: ______________________ First Name: ______________________

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ yes ☐ no
   If yes, please provide the following:
   Name of institution ______________________
   Address & phone number of institution (number and street) ______________________
   ____
6. Do you currently have end-stage renal (kidney) disease (ESRD)? ☐ yes ☐ no
   If yes, date of diagnosis ______/______/______
   See "Important information about this election form" section on the cover page for additional information about enrolling with ESRD.
7. Are you enrolled in Medi-Cal (state-subsidized medical plan)? ☐ yes ☐ no
   If yes, please provide your Medi-Cal number: ______________________

Our Senior Advantage Group Plan coverage includes Medicare Part D, a prescription drug benefit.

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
SOCIAL SECURITY ACT

Name of beneficiary
➤ ______________________

Medicare claim number	Sex
➤ ______________	➤ ______________
is entitled to	**Effective date**
Hospital Insurance Part A	➤ ______________
Medical Insurance Part B	➤ ______________

INTERNAL USE ONLY

Date Stamp ____________ Language Preference ____________ Rep's Name ____________

ICEP/IEP ____________ OEP ____________ AEP ____________ SEP (type) ____________

Employer Group Plan with Part D

Last Name: ______________________________ First Name: ______________________

Arbitration Agreement and Authorization to Exchange Information

Arbitration Agreement

I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding 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, 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 arbitration provision is contained in the *Disclosure Form* and/or *Evidence of Coverage.*

Authorization to Exchange Information

- I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to furnish information to Kaiser Foundation Health Plan, Inc., confirming my Part A (hospital), Part B (medical) and Part D (drugs) Medicare enrollment and, if my Medicare enrollment is terminated, the effective date of termination.
- I also authorize Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., or the Southern California Permanente Medical Group, or any holder of medical or other information about me, to release to CMS, or its intermediaries or carriers, any information needed to administer Title XVIII (the Medicare Section) of the Social Security Act.

PLEASE READ THE *CONDITIONS OF ELECTION* ON THE REVERSE SIDE OF THIS FORM.

I have read, understand, and agree to the statements in this enrollment form, including the restrictions on the use of non-Plan providers. I hereby apply for Kaiser Permanente Senior Advantage membership.

Please note: If the beneficiary is unable to sign, a court-appointed legal guardian or person designated in a Durable Power of Attorney for Health Care (DPAHC) or in a written Advance Directive or other person authorized by state law must sign below. A copy of the proof of legal guardianship, DPAHC, written Advance Directive, or proof of authorization by state law must be provided with this application.

Applicant Signature ______________________________ Date ______________

OR

Signature of representative by law ______________________________

Name (please print) ______________________________ Date ______________

Signature of any person who assisted in completion of this form (required if applicable) ______________________________ Date ______________

Name (please print) ______________________________ Relationship ______________