KAISER PERMANENTE®

Postal Service Health Benefit Plan

Kaiser Permanente Senior Advantage (HMO) or Medicare Prescription Drug Plan (PDP)

Postal Service Health Benefits (PSHB) Program Group Medicare Election Form

IMPORTANT. Please read the following before proceeding further:

If you are a PSHB annuitant and are eligible for Medicare Part D, you may have been or be in the process of being automatically enrolled in the Medicare Prescription Drug Plan (PDP).

- If you are already enrolled in the PDP plan and wish to remain on that plan, you **do not** need to complete this form.
- In limited circumstances you may need to complete this form to enroll in the Medicare Prescription Drug Plan (PDP), such as if you moved to a new service area, were disenrolled and are eligible for re-enrollment, or had another special qualifying event.

You also have the option to enroll your Medicare Parts A/B in the Group Medicare Advantage with Prescription Drug (MAPD) plan by completing this enrollment form and selecting the **MAPD** option at the top of page 1. This plan combines your medical and prescription drug benefits and provides more comprehensive benefits than the PDP option.

Filling out and returning the enrollment form is your first step to becoming a **Kaiser Permanente Senior Advantage** or **Medicare Prescription Drug Plan for Postal Service** member. If you and your eligible dependent are both applying, you'll each need to fill out a separate form.

For help completing the enrollment form, call Kaiser Permanente at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711** or visit **kp.org/postal.**

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

   You can also FAX or EMAIL your completed form to:
   FAX: **1-855-355-5334**
   EMAIL: **KPMedicareEnrollments@kp.org**
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Senior Advantage or Medicare Prescription Drug Plan.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus**.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

To Enroll in the PSHB Kaiser Permanente Senior Advantage or Medicare Prescription Drug Plan, Please Provide the Following Information

Select the plan you want to join: (Please only select one plan option)

☐ **Senior Advantage Plan (MAPD)** A Medicare Advantage Prescription Drug (MAPD) plan which includes Medical and Part D prescription drug coverage.

Please Note: You can enroll with Part B only.

☐ **Medicare Prescription Drug Plan (PDP)** An employer group sponsored stand-alone Prescription Drug Plan (PDP), which is Part D prescription drug coverage only. This plan is a stand-alone Part D prescription drug plan.

LAST Name:

FIRST Name: Middle Initial: Gender: ☐ Male ☐ Female

Home Phone Number: Mobile Phone Number: Birth Date: (mm/dd/yyyy)

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address)

Street Address:

City: State: ZIP Code:

Email Address:

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	
MEDICAL (Part B)	

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

2. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (mm/dd/yyyy):
   If no, name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse:
   Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution:
   Address of institution (number and street): Phone Number:

6. Requested effective date (subject to CMS approval):

Last Name _____ First Name _____

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Last Name _____ First Name _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

Last Name | First Name

Please Read and Sign Below

FOR CALIFORNIA ENROLLEES ONLY:

KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By completing this enrollment application, I agree to the following:

Kaiser Permanente is both a Medicare Advantage as well as a Medicare Prescription Drug (Part D) plan and has a contract with the Federal government. If enrolling in the Medicare Prescription Drug Plan, per Medicare guidelines I will need to keep either my Medicare Part A or Part B. If enrolling in the Medicare Advantage plan I will need to keep my Medicare Part B. I can only be in one Medicare Advantage or Part D plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Part D plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage or Medicare Prescription Drug plan because I can be enrolled in only one Senior Advantage or Medicare Prescription Drug plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage or Medicare Prescription Drug plan.

I understand that by enrolling in the PSHB Senior Advantage plan, where applicable I am affirmatively declining, and am in fact "opting out," of any automatic enrollment into the Kaiser Permanente Medicare Prescription Drug plan that may be pending for an effective date that is in alignment with or later than the effective date of this enrollment.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage or Kaiser Permanente Medicare Prescription Drug plan **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan or Medicare Prescription Drug plan.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Last Name | First Name

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage or Medicare Prescription Drug **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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. 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 from Medicare.

Enrollee or Authorized Representative Signature:

Today's Date:

If you are the authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this enrollment request on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above and provide your information below:

Name:

Address:

Phone Number: **Relationship to Enrollee:**

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente – Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

Last Name | First Name

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Do not complete this section if you are the enrollee or their legal/authorized representative.

Name:

Relationship to Enrollee:

Signature:

National Producer Number (Agents/Brokers only):

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #: | Effective Date of Coverage:

ICEP/IEP: | AEP: | SEP (type):

Kaiser Permanente Senior Advantage/Medicare Advantage for Postal Service Members (HMO) Senior Advantage 2/Medicare Advantage 2 Enrollment Application

☐ NCAL ☐ NCAL-Fresno ☐ SCAL ☐ Colorado ☐ Georgia ☐ Hawaii ☐ Mid-Atlantic States ☐ Northwest ☐ Washington

The PSHB enrollee (employee or retiree) must complete this form. By enrolling in Senior Advantage 2/Medicare Advantage 2, you and your covered dependents enrolled in Kaiser Permanente Senior Advantage/Medicare Advantage for Postal Service Members will be eligible to receive reimbursement of your Medicare Part B premium as described in the PSHB Senior Advantage 2/Medicare Advantage 2 Program Description. You must provide the enrollee's information below and the name(s) and Social Security number(s) for each dependent enrolled in Senior Advantage/Medicare Advantage for Postal Service Members.

PSHB enrollee

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

Street address

City | State | ZIP code | Telephone number

Dependent 1

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

Dependent 2

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

I understand that my signature on this application means that I have read, understand, and agree to the plan rules outlined in the Senior Advantage 2/Medicare Advantage 2 Program Description and PSHB Brochure. I am the enrollee and agree to enroll in the Program myself and/or any eligible dependents who have Senior Advantage/Medicare Advantage.

PSHB enrollee's signature or authorized representative* | Today's date (mm/dd/yyyy)

*If authorized representative, attach copy of legal documentation, such as Power of Attorney form

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San Diego, CA 92193-2400

Email: KPMedicareEnrollments@kp.org
Fax: 1-855-355-5334