KAISER PERMANENTE®

Individual and Family Plans

# Account Change Form

Kaiser Foundation Health Plan of Washington

## Instructions

- You may use this form to make plan changes or account changes to an existing Kaiser Foundation Health Plan of Washington (KFHPWA) 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. 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 are a subscriber ending coverage, your dependents' coverage automatically ends, and they have a special enrollment period to enroll in new coverage. You may choose to keep your children under 21 years of age on a child-only account.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. 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 KFHPWA plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KFHPWA plans or be added to your KFHPWA 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 | County | Phone (mobile phone if available) - -

Mailing address ☐ Check if same as home address

City

State | ZIP code

Email address

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Please check the boxes below for the changes you wish to make and list each family member affected. We won't make any changes for any family members you don't list.

**You can make the following changes during open enrollment or a special enrollment period.** To make a change other than listed below, you can call Member Services at **1-800-290-8900** (TTY **711**).

- ☐ I wish to change plans.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to change my child-only account to a family account with myself as the subscriber.
- ☐ I wish to add adult/family dental coverage for all members on this account.
- ☐ I wish to add pediatric dental coverage (for members 18 and younger).

(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

**Combine Accounts**

**Accounts can be combined during open enrollment or a special enrollment period.**

- ☐ I wish to add (a) family member(s) that is already on a Kaiser Permanente plan to my account. Doing this will end their existing plan. (Please indicate which family member(s) will move to your account in Section C.)

**Account ending**

First name

MI

Last name

Subscriber medical record number for account ending

**X**

Subscriber or parent/legal guardian for account ending

Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

**You can make the following changes any time during the year.** *(Note: For these changes, you can skip Sections D and E.)*

- ☐ 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 end my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ I wish to end my and my spouse's/domestic partner's coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ I wish to end my/our adult/family dental coverage only. (Everyone's adult coverage will be canceled).
- ☐ I wish to end pediatric dental coverage for my dependent(s) 18 and younger.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)

Requested effective date (not guaranteed)

☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

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

A domestic partner is a person registered and legally recognized as your domestic partner by Washington state. Washington state registered domestic partners are treated the same as a spouse.

### Spouse/Domestic partner

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents. Dependent children are eligible to enroll through the age of 25.

### Dependent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental 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)

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

### Dependent 2

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental 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)

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents. Dependent children are eligible to enroll through the age of 25.

**Dependent 3**

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add adult dental coverage ☐ End adult dental coverage ☐ Add pediatric dental coverage ☐ End pediatric dental 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) - -

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

## 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 within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-255-5169** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

☐ Loss of minimum essential health coverage (write the last full day you had coverage)*

Did you lose coverage with us (KFHPWA) that was provided by your employer?

☐ Yes ☐ No

If Yes, you have 2 options for continuing your coverage with us.

☐ Coverage that begins automatically the day after your employer coverage ends

☐ Coverage that begins based on when we receive your application. Please see **kp.org/specialenrollment** under "Loss of minimum essential health coverage" for more details

☐ Gaining or becoming a dependent through marriage or 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 the birth or placement of the child with you

☐ 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

☐ Determination by Washington Healthplanfinder of exceptional circumstances

☐ 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

☐ Discontinuation of employer contribution or government subsidization of COBRA premiums

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

*If your qualifying life event is loss of KFHPWA coverage, we may review membership records to check when and why you lost coverage.

## 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.

| | | |
|---|---|---|
| ☐ Bronze<br>☐ Bronze HSA X<br>☐ VisitsPlus Bronze | ☐ Silver HSA<br>☐ VisitsPlus Silver HD | ☐ VisitsPlus Gold |

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes
If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

## F. Choose your optional dental plan

If you want to add dental coverage from Delta Dental of Washington, please choose your dental plan here. Under the Affordable Care Act, pediatric dental coverage is required. If your account change form includes children 18 and younger and you don't enroll them in our pediatric dental plan, we'll contact you to submit an Attestation of Pediatric Coverage with proof of other pediatric dental coverage.
Dental coverage is provided by Delta Dental of Washington, 400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371. For more information, go to **deltadentalwa.com/group/kaiserpermanente**, call **1-800-290-8900** (TTY **711**), or contact your producer.

☐ Pediatric Dental #09140
☐ Adult/Family Basic Dental #09145

## G. Sign the form

- I understand that Kaiser Foundation Health Plan of Washington (KFHPWA) will rely on the information provided in this form, and that if any information is found to be fraudulent or intentionally misrepresented, KFHPWA may choose to terminate my coverage back to the coverage effective date.
- 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.
- If I worked with a producer, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $240, per member per year, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

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 Foundation Health Plan of Washington<br>Membership Administration<br>P.O. Box 23127<br>San Diego, CA 92193-9921 | **Or fax to:**<br>Membership Administration<br>**1-855-355-5334** | **Questions? Call**<br>**1-800-290-8900** (TTY **711**) |

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington, 2715 Naches Ave. SW, Renton, WA 98057.

# Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them less favorably because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity. We also:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Services at **1-888-901-4636** (TTY **711**).

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 (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator at P.O. Box 35191, Mail Stop: RCR-A1N-22, Seattle, WA 98124-5191 or by calling **1-888-901-4636** (TTY **711**). You can file a grievance in person or by mail, phone, or online at **kp.org/wa/feedback**. 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**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**

# 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 **1-888-901-4636** (TTY **711**).

**Español (Spanish): ATENCIÓN:** Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636** (TTY **711**).

**中文 (Chinese)：注意：**如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636** (TTY **711**)。

**Tiếng Việt (Vietnamese): CHÚ Ý:** Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636** (TTY **711**).

**한국어 (Korean): 참고:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636**(TTY **711**)번으로 문의하십시오.

**Русский (Russian): ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636** (TTY **711**).

**Tagalog: PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

**Українська (Ukrainian): УВАГА!** Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636** (TTY **711**).

**ភាសាខ្មែរ (Khmer)**៖ សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636** (TTY **711**)។

**日本語 (Japanese): 注意事項**：無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636** (TTY **711**) まで、お電話にてご連絡ください。

**አማርኛ (Amharic)፥ ማሳሰቢያ፥** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እገዛ አገልግሎቶች፣ በነጻ ለእርስዎ ይቀርባሉ፡ ወደ **1-888-901-4636** (TTY **711**) ይደውሉ።

**Oromiffa (Oromo): XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa yoo ta’e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636** (TTY **711**) irraatti bilbilaa.

**ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ**: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636** (TTY **711**) ‘ਤੇ ਕਾਲ ਕਰੋ।

**العربية (Arabic)**: انتباه:إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً.
اتصل بالرقم **1-888-901-4636** (TTY **711**)

**Deutsch (German): ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY **711**).

**ພາສາລາວ (Lao): ໂປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ,
ການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636** (TTY **711**).

**International Symbol for ASL (American Sign Language):**

KAISER PERMANENTE®