KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Kaiser Foundation Health Plan of Washington

Instructions

- If you are an existing Kaiser Foundation Health Plan of Washington (KFHPWA) member enrolled directly into a KPIF account, you may use this form to make plan changes or account changes. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- If you are an existing Kaiser Foundation Health Plan of Washington (KFHPWA) member enrolled through Washington Healthplanfinder, all account and plan changes to your existing coverage must be requested through wahealthplanfinder.org. If you are not sure how you are enrolled or need additional support, please call **1-800-255-5169** (TTY **711**).
- 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. You may choose to keep your children under 21 years of age on a child-only account. If you're ending KPIF coverage because you are newly eligible for Group coverage or Medicare, your dependents have a Special Enrollment Period to enroll in new KPIF coverage. Go to **kp.org/specialenrollment** or contact Member Services to learn more.
- 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)

City

State | ZIP code | County | Primary phone (mobile phone, if available) - -

Email address

Mailing address ☐ Check if same as 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 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**).

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

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

Combine KPIF 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 KPIF 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.)*

- ☐ End all coverage for myself and all family members.
- ☐ End all coverage for a family member.
- ☐ End my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ 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.
- ☐ End my/our adult/family dental coverage only. (Everyone's adult coverage will be canceled).
- ☐ End pediatric dental coverage for my dependent(s) 18 and younger.
- ☐ Make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)

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) / /

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) - -

Medical record number (if any)

Primary phone (mobile phone, if available) - -

Email address

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. Provide phone and email for dependents aged 18 and over only. 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) - -

Primary phone (mobile phone, if available) - -

Email address

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. Provide phone and email for dependents aged 18 and over only. Dependent children are eligible to enroll through the age of 25.

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) - -

Primary phone (mobile phone, if available) - -

Email address

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) - -

Primary phone (mobile phone, if available) - -

Email address

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.

Change in health coverage

☐ 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

☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)

☐ Discontinuation of employer contribution or government subsidization of COBRA premiums

Change in household

☐ 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

☐ Domestic violence or spousal abandonment occurring within the household

Change in residence

☐ Permanent relocation with access to new plans

Other qualifying life events

☐ Determination by Washington Healthplanfinder of exceptional circumstances

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

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	Silver	Gold
☐ Bronze	☐ VisitsPlus Silver 4500	☐ Gold HSA
☐ Bronze HSA	☐ Silver HSA	☐ VisitsPlus Gold
☐ VisitsPlus Bronze	☐ VisitsPlus Silver HD	☐ VisitsPlus Gold LD
	☐ VisitsPlus Silver X	

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 $20, per member per month, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information visit **healthy.kaiserpermanente.org/termsconditions**.

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:	Or fax to:	Questions? Call
Kaiser Foundation Health Plan of Washington Membership Administration P.O. Box 23127 San Diego, CA 92193-9921	Membership Administration **1-855-355-5334**	**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.

Nondiscrimination Notice

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.

The notice of nondiscrimination is available at https://healthy.kaiserpermanente.org/washington/language-assistance/nondiscrimination-notice

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**

Help in your language

English: ATTENTION: If you speak a language other than English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-888-901-4636** (TTY **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-888-901-4636** (TTY **711**)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-888-901-4636** (TTY **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-888-901-4636**로 전화해 주세요(TTY **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-888-901-4636** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-888-901-4636** (TTY **711**).

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-888-901-4636** (TTY **711**)។

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-888-901-4636**までお電話ください(TTY **711**)。

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-888-901-4636** ይደውሉ (TTY **711**)።

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-888-901-4636** irratti bilbilaa (TTY **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-888-901-4636** (TTY **711**).

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-888-901-4636** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-888-901-4636** an (TTY **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-888-901-4636** (TTY **711**).

International Symbol for ASL (American Sign Language):

XB0001444-60-25