

# 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'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)
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Last name
<input type="text"/>

Medical record number (if any)	Gender:	Social Security number (if any)
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared	<input type="text"/> - <input type="text"/> - <input type="text"/>

Home address (no P.O. boxes, please)
<input type="text"/>

City
<input type="text"/>

State	ZIP code	County	Phone (mobile phone if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

Mailing address	<input type="checkbox"/> Check if same as the home address.
<input type="text"/>	

City
<input type="text"/>

State	ZIP code
<input type="text"/>	<input type="text"/>

Email address
<input type="text"/>

**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**.

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

(Restrictions apply for special enrollment periods. See [kp.org/specialenrollment](http://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

Date (mm/dd/yyyy)

Subscriber or parent/legal guardian for account ending

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

- |                                                                                                                                                           |                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> I wish to end medical coverage for myself or for a family member.                                                                | <input type="checkbox"/> Someone on my account stopped using tobacco.<br>(Please indicate which family member in Section C.) |
| <input type="checkbox"/> I'm ending my coverage and I wish to keep my child(ren) on a child only account.                                                 | <input type="checkbox"/> I wish to end my/our adult/family dental coverage<br>(everyone's coverage will be canceled).        |
| <input type="checkbox"/> I'm ending my and my spouse's/domestic partner's coverage and I wish to keep my child(ren) on a child only account.              | <input type="checkbox"/> I wish to end pediatric dental coverage for my dependent(s)<br>18 and younger.                      |
| <input type="checkbox"/> I wish to 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)

### 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.

<b>Spouse/Domestic partner</b>	<input type="checkbox"/> Add medical coverage	<input type="checkbox"/> Add adult dental coverage
	<input type="checkbox"/> End medical coverage	<input type="checkbox"/> End adult dental coverage

Name change

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.

<b>Dependent 1</b>	<input type="checkbox"/> Add medical coverage	<input type="checkbox"/> Add adult dental coverage	<input type="checkbox"/> Add pediatric dental coverage
	<input type="checkbox"/> End medical coverage	<input type="checkbox"/> End adult dental coverage	<input type="checkbox"/> End pediatric dental coverage

Name change

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

<b>Dependent 2</b>	<input type="checkbox"/> Add medical coverage	<input type="checkbox"/> Add adult dental coverage	<input type="checkbox"/> Add pediatric dental coverage
	<input type="checkbox"/> End medical coverage	<input type="checkbox"/> End adult dental coverage	<input type="checkbox"/> End pediatric dental coverage

Name change

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



## 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. Choosing a health plan is based on your county. See the county list below to determine which health plan is available to you. 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.

Available in Benton, Columbia, Franklin, Island, Lewis, Mason, Skagit, Walla Walla, Whatcom, Whitman, and Yakima counties

- |                                       |                                         |
|---------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Bronze       | <input type="checkbox"/> Silver HSA     |
| <input type="checkbox"/> Bronze HSA X | <input type="checkbox"/> Flex Silver HD |
| <input type="checkbox"/> Flex Bronze  | <input type="checkbox"/> Flex Gold      |

Available in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties

- |                                              |                                                |
|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Virtual Plus Bronze | <input type="checkbox"/> Virtual Plus Silver X |
| <input type="checkbox"/> Bronze              | <input type="checkbox"/> Silver HSA            |
| <input type="checkbox"/> Bronze HSA X        | <input type="checkbox"/> Flex Silver HD        |
| <input type="checkbox"/> Flex Bronze         | <input type="checkbox"/> Flex Gold             |

## 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](http://deltadentalwa.com/group/kaiserpermanente), call **1-800-290-8900**, or contact your producer.

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

## G. Sign the form

- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- 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 \$216, per member per year, plus a potential bonus. To learn more, visit [kp.org/brokercompensation](http://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  
Membership Administration  
P.O. Box 23127  
San Diego, CA 92193-9921

**Or fax to:**  
Membership Administration  
**1-855-355-5334**

**Questions? Call**  
**1-800-290-8900 (TTY 711)**

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington, 1300 SW 27th Street, Renton, WA 98057.

## Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable Federal and Washington state civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
  - Assistive devices (magnifiers, Pocket Talkers, and other aids)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these 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, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance 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/online-services/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 សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃក៏មានសម្រាប់អ្នក។ 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 አገዛ አገልግሎቶች፣ በነጻ ለአርስዎ 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 ਮੁਫਤ 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): ໄປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636 (TTY 711)**.

