KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Kaiser Foundation Health Plan of Washington

Instructions

- 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. 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 Kaiser Foundation Health Plan of Washington (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. Please select one: I'm the ☐ subscriber, ☐ spouse/domestic partner or dependent child 18 and older, or ☐ parent or legal guardian

First name | MI | Date of birth (mm/dd/yyyy) __/__/____

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female | Phone *I understand I may be contacted via text message.* ___-___-____

Home address (no P.O. boxes, please)

City

State | ZIP code | County | Social Security number (if any) ___-__-____

Mailing address ☐ Check if the same as the home address.

City

State | ZIP code

Email address *I understand I may be contacted via email.*

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 on the next page, list each family member affected. We won't make any changes for any family members you don't list.
- The subscriber, or parent or legal guardian for subscribers under 18, can make all the changes below for any family members. Dependents 18 and older can make changes – those marked with an asterisk (*) below – only for themselves.

You can make the following changes during open enrollment or a special enrollment period.
(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

- ☐ I wish to change plans.
- ☐ I wish to combine accounts.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to add medical coverage for myself on my family's account 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).

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

- ☐ I'm ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.*
- ☐ I wish to change the subscriber.
- ☐ I wish to change the parent/legal guardian on a child-only account.
- ☐ I wish to end medical coverage for myself* or for a family member.
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.

Requested effective date (not guaranteed)

__ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ 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.)*
- ☐ I wish to end my/our adult/family dental coverage (everyone's coverage will be canceled).
- ☐ I wish to end pediatric dental coverage for my dependent(s) 18 and younger.

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

Spouse/Domestic partner

☐ 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

Choose one: ☐ Spouse ☐ Domestic partner

Last name

Social Security number (if any) ___ - __ - ____

Medical record number (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

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 4 dependents with a change, attach a copy of this page and complete the information for those dependents.

Dependent 1

☐ 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

Last name | Social Security number (if any) ___ - ___ - ____

Medical record number (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy) __ / __ / ____

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

☐ 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

Last name | Social Security number (if any) ___ - ___ - ____

Medical record number (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy) __ / __ / ____

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 3

☐ 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

Last name | Social Security number (if any) ___ - ___ - ____

Medical record number (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy) __ / __ / ____

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 4

☐ 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

Last name | Social Security number (if any) ___ - ___ - ____

Medical record number (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy) __ / __ / ____

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.** Visit **kp.org/specialenrollment** or call **1-800-290-8900** for more about qualifying life events.

☐ 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

☐ Changes in employer health coverage making you eligible for a premium tax credit

☐ 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

☐ Loss of COBRA health coverage due to discontinuation of employer contribution

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. For more about minimum essential coverage, visit **kp.org/specialenrollment**.

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.

CoreSelect Network

- ☐ Bronze
- ☐ Bronze HSA
- ☐ Flex Bronze
- ☐ Silver HSA
- ☐ Flex Silver HD
- ☐ Flex Gold

Connect Network

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

- ☐ Virtual Plus Bronze

F. Choose your dental plan

If you want to add dental coverage, 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.

- ☐ Pediatric Dental #09140
- ☐ Adult/Family 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 $192, per member per year, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

Note: The subscriber and all dependents 18 and older making a change must sign the form. If there are more than 4 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Subscriber/new subscriber (parent or legal guardian for subscribers under 18)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

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/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 otro idioma que no sea español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Llame al **1-888-901-4636** (TTY **711**).

中文 (Chinese)：注意：如果您使用繁體中文，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, hiện có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-901-4636** (TTY **711**)**.**

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-901-4636** (TTY **711**) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните **1-888-901-4636** (TTY **711)**.

Tagalog: PAUNAWA: Kung nagsasalita ka ng wika maliban sa 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, ви можете звернутися до безкоштовної служби мовної підтримки. 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：英語以外の言語を話される場合、無料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 ሚከተለው ቁጥር ይደውሉ **1-888-901-4636** (መስማት ለተሳናቸው **711**)።

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 ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-888-901-4636** (TTY **711**) ‘ਤੇ ਕਾੱਲ 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,
ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-888-901-4636** (TTY **711**).