VIRGINIA

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street
Rockville, MD 20852

Kaiser Permanente Insurance Company (KPIC)
One Kaiser Plaza
Oakland, CA 94612

KFHP-MAS/KPIC SMALL GROUP ENROLLMENT AND CHANGE FORM HMO PLAN AND FLEXIBLE CHOICE OFFERINGS

INSTRUCTIONS

Welcome

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) and Kaiser Permanente Insurance Company (KPIC). We look forward to receiving your Enrollment and Change form. If you have any questions concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired before signing this form.

After you have completed this form, please sign and return it to your employer's benefits office. **Do not send this form to KFHP-MAS/KPIC unless otherwise instructed.**

If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired for more information.

How to complete this form. Please print

Use this form to enroll, waive or change (add or delete) your family's membership status. To be a subscriber, you must live, work, or reside within our service area and you must be an employee who meets all of your employer's eligibility guidelines. **If you are electing to waive coverage, you only need to complete Sections A and C.** If you have any questions, contact your employer's benefits office.

Section A: Applicant information

Please provide information about yourself.

Section B: Benefit plan requested

Please provide information for the plan that you are selecting.

Section C: Waiver of coverage

Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. You will need complete and sign this section

Section D: Family information

Make sure your dependents meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office.

Maximum Age/Disabled dependent

Please complete this section to list any dependents that exceed your employer's' maximum limiting age requirements or are disabled. You will be requested to provide additional information to document dependents that are indicated in this section.

Dependents residing at another PERMANENT address

Please use this section to document any dependents that have another permanent address other than that of the subscriber. You will be requested to provide additional information to document dependents that are indicated in this section. This section does not apply to dependents who are full time students living in temporary housing while attending their classes.

Section E: Other coverage

Tell us if you, your spouse or domestic partner, or other family dependents are covered by other group health insurance plans. This may occur when the spouse or domestic partner is employed and has health care benefits from one or more health plan(s).

If you or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you may be able to eliminate some of your out-of-pocket expenses for approved services now only partially covered by those plans.

If the Coordination of Benefits provisions apply to you, your signature on this form will permit KFHP-MAS/KPIC to bill any other health care policy that is determined to be the primary carrier in accordance with the National Association of Insurance Commissioners (NAIC) guidelines including, but not limited to Medicare and Workers' Compensation, so long as you are enrolled in the primary plan and such plan remains primary to KFHP-MAS/KPIC plan. Your signature authorizes KFHP-MAS/ KPIC and its employees to release any records or information with respect to any claim for covered services that may be requested by your other carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call a Member Services representative at [1-800-777-7902] or [TTY 711] for the deaf, hard of hearing, or speech impaired.

Section F: Subscriber signature

Review and sign this form. Before doing so, please make certain you have read all coverage materials. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card.

Section G: Employer Authorized Representative Signature

To be completed by employer

MISREPRESENTATION

If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statements, or you knowingly or intentionally fail to provide requested information, you may have violated state law.

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Company Name	Effective Date	Date of Qualifying Event	Group Number

❑ New enrollment ❑ Self only ❑ Self and dependent(s) ❑ Open enrollment ❑ New hire	❑ Qualifying life event ❑ COBRA ❑ Rehire/reinstatement ❑ Waiver ❑ Other ______________	❑ Change of coverage ❑ Add spouse or domestic partner* ❑ Add dependent child* ❑ Name change* ❑ Other ____________________	❑ Employee termination ❑ Remove spouse or domestic partner* ❑ Remove dependent child* ❑ Cancel coverage

A. APPLICANT'S INFORMATION: Must be completed by the employee

EMPLOYEE LAST NAME | FIRST NAME | MI | SUFFIX

ADDRESS

APARTMENT # | CITY

STATE | ZIP CODE | HOME PHONE | WORK PHONE

Social Security Number	Date of Birth		Email Address:
☐☐☐-☐☐-☐☐☐☐	☐☐/☐☐/☐☐☐☐	☐ Male ☐ Female	

Have you or any dependents requesting coverage ever been covered as a member of KFHP-MAS? ❑ Yes ❑ No	Check One: ❑ Full Time or ❑ Part Time

If you do not physically work at your employer's address, please provide the address where you are currently working:

B. BENEFIT PLAN REQUESTED

Choose your Small Group health plans which include pediatric dental essential health benefits and adult preventive dental benefits. [HMO], [DHMO (Deductible HMO)], [HDHP], [Added Choice POS], and [Flexible Choice] (Option 1: HMO) benefits are underwritten by KFHP-MAS. [Flexible Choice] (Option 2: POS & Option 3: Out-of-network) benefits are underwritten by KPIC.

MEDICAL			DENTAL ENHANCEMENTS (OPTIONAL)
Product	**Service delivery options**		
[HMO]:	❑ Signature	❑ Select	❑ **Employer-selected adult dental rider** Dental benefits are underwritten by KFHP-MAS and administered by Dominion National.
[Deductible HMO]:	❑ Signature	❑ Select	
[HDHP]:	❑ Signature	❑ Select	
[Added Choice POS]:	❑ Signature	❑ Select	
[Flexible Choice]:	❑ Signature		
Plan Selected:			

*Additional documentation may be required

C. WAIVER OF COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following: ❑ All coverage ❑ Coverage for my spouse or domestic partner ❑ Coverage for my child(ren) *I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit documentation to support enrollment outside the Open Enrollment period and coverage may be subject to late enrollment provisions, as allowed by law and as directed by my employer.*	**Reason for refusal:** ❑ Other group coverage sponsored by my spouse's or domestic partner's employer* ❑ Other group coverage sponsored by another organization* ❑ Medicare/Medicaid/TRICARE* ❑ Individual coverage* ❑ Parental coverage (must be under 26 or disabled)* ❑ Other reasons (please explain) _____
Waiving Employee Signature	**Date**

D. FAMILY INFORMATION – Must be completed by the employee

If additional space is needed, please use another form and attach to this form.

SPOUSE OR DOMESTIC PARTNER (If eligible under your plan)

LAST NAME | FIRST NAME | MI | SUFFIX

Social Security Number | Date of Birth | Relationship | Male ☐ Female ☐

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social Security Number | Date of Birth | Relationship | Male ☐ Female ☐

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social Security Number | Date of Birth | Relationship | Male ☐ Female ☐

CHILD LAST NAME | FIRST NAME | MI | SUFFIX

Social Security Number | Date of Birth | Relationship | Male ☐ Female ☐

Are any of your listed dependents over the Groups' maximum age(s)? If yes, please complete the following:

Name(s) (Last, First, MI)	Disabled*	Reason
	❑ Yes ❑ No	
	❑ Yes ❑ No	

*Additional documentation may be required

Do any of your dependents above permanently reside at another address? ❑ Yes** ❑ No
If yes, please complete the following:

Dependent Last Name	First Name	M.I.
Home Address		Apt. No.
City	State	ZIP Code

**If additional space is needed, please use another form and attach it to this form.

E. OTHER COVERAGE

Including yourself, list any person(s) below that have other health coverage?

Name	Insurance Carrier Name	Policy Number	Telephone Number

Are you or any of your dependents eligible for Medicare? ❑ Yes ❑ No

F. SUBSCRIBER SIGNATURE

❑ **Request for Enrollment**
I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this form is accepted, coverage will be provided according to the terms and conditions of my employer's contract with KFHP-MAS/KPIC. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay required subscription charges to my employer.

❑ **Request for Cancellation**
I hereby request on behalf of myself and each dependent listed above, that my coverage be cancelled.

I authorize KFHP-MAS/KPIC and its employees to release any records or information with respect to any claim for covered services that may be requested by another insurance carrier. Such authorization shall be valid for the duration of coverage.

I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

Employee/Applicant Signature	Date

G. EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE

I hereby certify that this (these) enrollment(s) has (have) been reviewed and meet(s) all eligibility requirements

Printed or Typed Name	Title	Phone Number
Employer Signature		Date