KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

Individual and Family Plans

Account Change Form
Virginia

Instructions

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is further referred to as "Health Plan," "we," "us," "our," and "Kaiser Permanente" throughout this form.

- You may use this form to make plan changes or account changes to an existing Kaiser Permanente for Individuals and Families (KPIF) 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 KPIF plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF 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 | 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

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.

You can make the following changes only during open enrollment or a special enrollment period.
To make a change other than listed below, you can call Member Services at **1-800-777-7902.**

- ☐ I wish to change plans.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to add optional adult dental coverage (for members 19 and older).
- ☐ I want 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** 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 _____ 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.)*

- ☐ 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 coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)
- ☐ I wish to end optional adult dental coverage.

Requested effective date (not guaranteed)
☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

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

Spouse

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

First name | MI

Last name

Date of birth (mm/dd/yyyy)

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

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents.

Dependent 1

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

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

Last name

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

Dependent 2

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

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

Last name

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

Dependent 3

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

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

Last name

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

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** 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)*
- ☐ Gaining or becoming a dependent through marriage
- ☐ 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 the health benefit exchange 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 Kaiser Permanente 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.

☐ KP VA Bronze 6500 Ded/Vision	☐ KP VA Silver 2500 Ded/Vision	☐ KP VA Gold 0 Ded/Vision	☐ KP VA Standard Platinum 0 Ded/Vision
☐ KP VA Bronze 7000 Ded/HSA/Vision	☐ KP VA Silver 4500 Ded/Vision	☐ KP VA Standard Gold 1500 Ded/Vision	☐ KP VA Catastrophic 9200 Ded/Vision*
☐ KP VA Bronze 7500 Ded	☐ KP VA Standard Silver 5000 Ded/Vision	☐ KP VA Gold 1250 Ded/200 Rx Ded/Vision	
☐ KP VA Standard Bronze 7500 Ded/Vision	☐ KP VA Silver Virtual Forward 3500 Ded	☐ KP VA Gold 2000 Ded/Vision	
	☐ KP VA Silver Virtual Forward 4000 Ded	☐ KP VA Gold Virtual Forward 2350 Ded	

*To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your account change without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

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 adult dental plan

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. We also offer optional dental plans for adults 19 and older for an additional monthly charge.

If you want to add optional adult dental coverage, please choose a dental plan:

- ☐ KP Smile KPIF Dental Copay
- ☐ KP Smile KPIF Dental C-POS Basic
- ☐ KP Smile KPIF Dental C-POS High
- ☐ KP Smile KPIF Dental Copay+Ortho
- ☐ KP Smile KPIF Dental C-POS Basic+Ortho
- ☐ KP Smile KPIF Dental C-POS High+Ortho

☐ No. I'm not interested in the optional adult dental coverage.

G. Sign the form

- I understand that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), will rely on the information provided in this form. I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B. I understand if I commit fraud or intentional misrepresentation of material fact, then Health Plan may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30-days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.
- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.**
- 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 broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $18 per member per month 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 regarding this form.

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 Permanente for Individuals and Families P.O. Box 23127 San Diego, CA 92193-9921	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call:** **1-800-777-7902**

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

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