KAISER PERMANENTE®

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

Kaiser Permanente for Individuals and Families

ACCOUNT CHANGE FORM

Grandfathered
Maryland

Instructions

There are different types of plan and account changes you can make with this form. Please fill out your information in Section A, look at the options listed below, and complete the section(s) for the plan or account change(s) you'd like to make. In Section A, write the start date you'd like for your plan or account change (start dates are not guaranteed).

A. Fill Out Your Information

Fill this out if you're the subscriber/new subscriber or person responsible for payment.

○ Check here if your address or phone numbers have changed.

First name	MI	Last name	Medical record number

Home address	City	State	ZIP
Billing address (○ Check if the same as the home address.)	**City**	**State**	**ZIP**

Phone	Social Security number	Requested future start date (mm/01/yyyy) (must be the 1st of the month)
( ) -		

B. What Change(s) Do You Want to Make?

Please check the circles for the changes you wish to make, and below, list each family member who is affected. If there are other members on your account who aren't listed, we won't make any changes for them.

○ I am ending my coverage and I wish to have my spouse/domestic partner as the subscriber.

○ I am ending my coverage on a family plan and wish to continue on my own on an individual plan.

○ I wish to switch the subscriber and spouse/domestic partner roles on our current plan.

○ I wish to combine accounts. (Please pick your plan on page 2.)

○ I wish to change plans. (Please select your plan on page 2.)

○ I wish to add medical coverage for an eligible dependent such as a spouse/domestic partner, newborn or newly adopted child (for information about eligible dependents, please review your *Membership Agreement*).

○ I wish to end medical coverage for a family member.

You can change to a non-grandfathered plan during a special enrollment period outside of the open enrollment period which is November 1, 2015, through January 31, 2016.

- During a special enrollment period, applicants and their dependents can make certain changes following a triggering event, as defined in the Enrolling During a Special Enrollment Period guide.
- This form and payment of your first month's premium must be received by Kaiser Permanente within 60 days of the triggering event, unless stated in the guide.

Each family member listed above will be moved into the plan you select. If you wish to enroll family members in different plans, please send a separate form for each plan.

After 30 days have passed from your new grandfathered plan's start date, you won't be able to change back to your previous plan.

C. Which Family Members Are Affected by the Change?

Spouse/domestic partner ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

(continues on next page)

Your name_____

C. Which Family Members Are Affected by the Change? *(continued from previous page)*

Dependent 1 ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 2 ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 3 ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 4 ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 5 ○ Add medical coverage ○ End medical coverage

First name	Middle name	Last name	Medical record number (if any)

Gender ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Option 1: Choose Your Health Plan

If your desired plan is listed below your current plan, you **may** change into that plan with the following exceptions:

- If you're currently enrolled in a copay plan(s), you cannot select a different grandfathered copay plan. You can only change to a grandfathered deductible plan.
- If you're currently enrolled in the $750 Ded/20% Deductible HMO Plan with no Rx GFP, you cannot select a different grandfathered plan.
- If your desired plan is listed above your current plan, you may **not** change into that plan.

Fill in the circle next to the plan you'd like to change into.

○ HMO $10/$20 Copay Plan GFP
○ HMO $20/$30 Copay Plan GFP
○ HMO $30/$40 Copay Plan GFP
○ HMO $40/$50 Copay Plan GFP
○ $500 Ded/20% Deductible HMO Plan GFP
○ $750 Ded/20% Deductible HMO Plan with Rx GFP
○ $750 Ded/20% Deductible HMO Plan no Rx GFP
○ $1,000 Ded/30% Deductible HMO Plan GFP
○ $1,250 Ded/20% Deductible Health Plan GFP
○ $1,750 Ded/20% HSA-Qualified Deductible Health Plan GFP
○ $2,500 Ded/20% HSA-Qualified Deductible Health Plan GFP
○ $4,500 Ded/20% Deductible Health Plan GFP
○ $8,000 Ded/0% Deductible Health Plan GFP

(continues on next page)

Your name_____

Sign the Form *(continued from previous page)*

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, and my coverage may be declared null and void. Penalties may include imprisonment, fines, and the cancellation of your policy. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.**

For all account and plan changes, the subscriber and any new dependents 18 or older must sign.

Subscriber/new subscriber (parent or legal guardian for children under age 18) **X**	**Date (mm/dd/yyyy)**
Spouse/domestic partner (18 or older) **X**	**Date (mm/dd/yyyy)**
Dependent (18 or older) **X**	**Date (mm/dd/yyyy)**
Dependent (18 or older) **X**	**Date (mm/dd/yyyy)**
Dependent (18 or older) **X**	**Date (mm/dd/yyyy)**

Contact Information

Mail to: Membership Administration Dept./KPIF 5W
Kaiser Permanente Individuals and Families Plans
2101 East Jefferson St.
Suite 100
Rockville, MD 20852-9995

Or fax to: Membership Administration
301-388-1615

Questions? Call 301-468-6000 or 1-800-777-7902.