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

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

EMPLOYER GROUP
SUBSCRIBER ENROLLMENT & CHANGE FORM

Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). We look forward to receiving your form. **If you have any questions concerning the benefits and services that are provided by or excluded under this form, please contact a Member Services representative 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 KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.

If you are Medicare-eligible, there is a separate enrollment process. Please call a Member Services representative for more information.

How to Complete This Form – Please Print

Use this form to enroll, waive or change (add or delete) your family members' membership status. To be a Subscriber, you must live or work 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 2, 3 and sign Section 9.** If you have any questions, contact your employer's benefits office.

Section 1: Employer Sign-off

Your employer will complete this section.
Note: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) underwrites the Kaiser Permanente providers (HMO) portion of the Flexible Choice Plan. Kaiser Permanente Insurance Company (KPIC) underwrites the Participating providers and Out-of-Network providers portion of the Kaiser Permanente Flexible Choice Plan.

Section 2: Tell Us About Yourself

Please provide information about yourself. To indicate your choice of primary care physician, please see the line titled "Self" in Section 4.

Sections 3 & 9: Waiver of Coverage

Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. You will also need to complete Section 2 and sign Section 9.

Section 4: Tell Us About Your Dependents & Select a Primary Care Physician

Make sure your dependents meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office. Please provide the relationship of each dependent to the Subscriber, for example, son, daughter, etc. Please indicate "Yes" or "No" if a dependent is a full-time student. To select a primary care physician, please review the KFHP-MAS Provider Directory and enter the provider code of the primary care physician for you and each member of your family. The primary care physician must be listed in the KFHP-MAS portion of the Provider Directory. To obtain a directory, please call Member Services or see our Web site at **http://www.kaiserpermanente.org**

Section 5: Tell Us About Other Insurance Coverage

Tell us if you, your spouse, or other family dependents are covered by other group health insurance plans. This may occur when both spouses are employed and have 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 you qualify for Coordination of Benefits, your signature on this form will permit KFHP-MAS or 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, Medicaid, Motor Vehicle Insurance (when permitted by law), Workers' Compensation, Tricare, Veterans Administration, so long as you are enrolled in the primary plan and such plan remains primary to Kaiser Permanente Flexible Choice. Your signature authorizes KFHP-MAS and/or KPIC to release any records or information, with respect to any claim for covered services, that may be requested by your primary carrier. Such authorization shall be valid for the duration of coverage. For more information on Coordination of Benefits, please call Member Services.

Section 6: Mandatory Point-of-Service Option

This applies only when Kaiser Permanente is the sole carrier for health care services within your group. Please check with your employer benefits office to see if you are eligible for this mandatory point-of-service option. You will not be enrolled in the mandatory point-of-service option unless you are eligible and elect to enroll.

Section 7: Mandatory DENTAL Point-of-Service Option

This applies only when (a) Kaiser Permanente is the sole carrier for dental services within your group, and (b) for Employer Group contracts issued in the State of Maryland only. Please check with your employer's benefits office to see if you are eligible for this mandatory dental point-of-service option. You will not be enrolled in the mandatory dental point-of-service option unless you are eligible for and elect to enroll.

Section 8: Subscriber/Subscriber Sign-off

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

MISREPRESENTATION

If you knowingly or intentionally file an enrollment form or statement of claim containing any materially false or deceptive statement, or you knowingly or intentionally fail to provide requested information, you may have violated state law which could subject you to civil and/or criminal penalties. **You will also be liable to KFHP-MAS or KPIC for the cost of health care services provided because of the false or misleading information or omission.**

RECEIVING CARE AFTER ENROLLMENT

Your member ID card should arrive shortly after your effective date, which is determined by your employer. However, if you do not receive a member ID card, contact our Member Services Department.

Member Services:

Washington, DC Metropolitan area:	301-468-6000
Outside Washington, DC Metropolitan area:	800-777-7902
TTY Services:	301-879-6380

To schedule an appointment or to receive medical advice, call:

Washington, DC Metropolitan area:	703-359-7878
TTY Services:	703-359-7616
Outside Washington, DC Metropolitan area:	800-777-7904
TTY Services:	800-700-4901

In a medical emergency, call 911 or go to the nearest emergency facility. If you are unsure of your condition and require immediate medical advice, call 800-677-1112.

REMOVE THIS INSTRUCTION SHEET PRIOR TO SUBMITTING FORM

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EMPLOYER GROUP
SUBSCRIBER ENROLLMENT & CHANGE FORM

SECTION 1: EMPLOYER SIGN-OFF *(TO BE COMPLETED BY EMPLOYER GROUP)*

Group/Subgroup Number		Date of Hire		Effective Date of Coverage	

Enrollment Type	❑ New Hire	❑ Open Enrollment	❑ Add/Delete Dependent	❑ Waiver of Coverage
	❑ Other (please explain):			
Product Selection	❑ HMO ❑ Signature ❑ Select	❑ KP Flexible Choice Plan *	*Please see instructions under Sections 6 and 7*	
	❑ Added Choice Plan ❑ Signature ❑ Select	❑ Other (please explain)	❑ Mandatory POS	❑ Mandatory Dental POS (MD contracts only)
Employment Status	❑ Full Time	❑ Part Time	❑ 1099 Contractor	❑ Other
	Did employee complete and submit an I9 form?		❑ No	❑ Yes
Employer Authorized Representative Signature	*I hereby certify under penalty of perjury that this(these) enrollment(s) has been reviewed and meet(s) all eligibility requirements*			
	Printed or Typed Name/Title			
	Employer Signature			
	Date	Telephone	Fax	

SECTION 2: TELL US ABOUT YOURSELF

Subscriber Name (last, first, middle)					
Home Street Address					
City		State		Zip	
Telephone Numbers	Home		Work		Email
Social Security Number		Sex	❑ Male	❑ Female	Date of Birth
Your Employer's Name					
Address**					
City**		State**		Zip**	

* **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) underwrites the Kaiser Permanente Providers (HMO) portion of the Kaiser Permanente Flexible Choice Plan. Kaiser Permanente Insurance Company (KPIC) underwrites the Participating Providers (PPO) and Out-of-Network Providers (Indemnity) portions of the Kaiser Permanente Flexible Choice Plan.**

** **If you do not actually work at your Employer's primary business address, please indicate the address for your place of work.**

SECTION 3: WAIVER OF COVERAGE BY ELIGIBLE EMPLOYEE/DEPENDENTS

Please assure Section 2 is completed and sign Section 9

Reason for Waiver	❑ Spousal Coverage	❑ Military/V.A. Benefit	❑ Other Coverage (please explain)
	❑ Individual Policy	❑ Medicare/Medicaid	
	❑ No Coverage		

SECTION 4: TELL US ABOUT YOUR DEPENDENTS & SELECTING A PRIMARY CARE PHYSICIAN

		Relationship to Subscriber	Last, First, Middle Initial	M or F	Social Security Number	Date Of Birth	Full-Time Student Y or N	Provider (PCP) Code	PCP Location Code
SELF									
Spouse	❑ Add ❑ Remove								
Dependent	❑ Add ❑ Remove						❑ No ❑ Yes		
Dependent	❑ Add ❑ Remove						❑ No ❑ Yes		
Dependent	❑ Add ❑ Remove						❑ No ❑ Yes		

Have you or any of your dependents listed above ever been members of Kaiser Permanente before? If Yes, print current name, the name under which each was covered, if different, and provide their former medical record number:	❑ No ❑ Yes
Do any of the dependents listed above live at another address? If Yes, list name and address and explain the circumstances:	❑ No ❑ Yes

If any dependent's last name is different from yours, please explain:

SECTION 5: TELL US ABOUT OTHER INSURANCE COVERAGE

Are you or any member of your family covered by Medicare or Medicaid? If Yes, please complete the following:	❑ No ❑ Yes

Medicare/Medicaid Number		Part A Effective Date		Part B Effective Date	

Are you or any member of your family covered by another group health insurance plan? If Yes, please complete the following:	❑ No	❑ Yes

Name of Plan		Phone # of Plan	

Policy #		Group #		Persons Covered	

Effective Date		Termination Date (if applicable)	

Name of Employer Who Provides Coverage		Phone #	

SECTION 6: MANDATORY POINT OF SERVICE OPTION

Applies ONLY when Kaiser Permanente is the sole carrier for health care coverage

Reminder: See instructions

Under State law, you may purchase a point-of-service option as an additional benefit. A point-of-service option allows you to obtain covered health care services from physicians and other providers outside the HMO network. Your employer has the choice to pay for this point-of-service option, pay a percentage of the cost of this option, or require you to pay for the entire cost of this option.
Please check with your employer's benefits office to see if you are eligible for the mandatory point-of-service option. There is a separate form to be completed and submitted along with this form in the event that you elect to enroll. You will not be enrolled in this point-of-service option unless you are eligible and elect to enroll.

Do you wish to purchase the mandatory point-of-service option? ❑ **No** ❑ **Yes**

SECTION 7: MANDATORY DENTAL POINT OF SERVICE OPTION

Applies ONLY when Kaiser Permanente is the sole carrier for dental coverage for Employer Group Contracts Issued in the STATE OF MARYLAND.

Reminder: See instructions

Under State of Maryland law, you may purchase a dental point-of-service option as an additional benefit. A dental point-of-service option allows you to obtain covered dental care services from dentists and other providers outside the HMO network. Your employer has the choice to pay for this dental point-of-service option, pay a percentage of the cost of this option, or require you to pay for the entire cost of this option. Please check with your employer benefits office to see if you are eligible for the mandatory point-of-service option. There is a separate form to be completed and submitted along with this form in the event that you elect to enroll. You will not be enrolled in this point-of-service option unless you are eligible for and elect to enroll.

Do you wish to purchase the mandatory dental point-of-service option? ❑ **No** ❑ **Yes**

SECTION 8 : EMPLOYEE – COVERAGE REQUEST SIGN-OFF

Please be sure to review your form for completeness.

I hereby apply for enrollment in Kaiser Permanente Flexible Choice or change the membership status of any eligible dependents and authorize my employer to make deductions, if any are required, as my contribution for the premium.

I hereby assign KFHP-MAS or KPIC authorization to bill any other applicable group insurance plan for all covered services so long as I am enrolled in Kaiser Permanente Flexible Choice and such other group plan is primary under the applicable Coordination of Benefits provisions. I understand that this coordination of benefits does not limit my rights to receive reimbursement for services I receive from non-Kaiser Permanente physicians subject to all terms and conditions of the Kaiser Permanente Flexible Choice plan.

The information provided above is true and correct to the best of my knowledge and meets the eligibility guidelines of my employer. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information of a material nature.

I also understand that this form and any services rendered by KFHP-MAS or KPIC may involve the use of confidential information protected by State and Federal law. All confidential information shall be treated in accordance with the privacy policies of KFHP-MAS and KPIC. Copies of such policies are available by calling Member Services at 301-468-6000. I am entitled to a copy of each policy and consent to the use of any confidential information in accordance with those policies.

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 form.

Before you sign this form, make sure you have filled it out completely including selecting a primary care physician for you and each of your enrolled dependents (Section 4).

Signature of Employee		**Date of Form**	

SECTION 9: WAIVER OF COVERAGE SIGN-OFF

Please be sure to review section 2 for completeness.

I hereby certify that the medical benefits provided by my employer have been explained to me and that I have been given an opportunity to apply for coverage. However, I choose not to participate in the plan. I understand that if I choose to enroll at a later time, I may apply only during the designated annual open enrollment period, except if I lose my other health care coverage as the result of: (i) exhaustion of my COBRA OR Continuation of Coverage under applicable state law coverage, or (ii) in the case of non-COBRA coverage, loss of eligibility or termination of my previous coverage, or (iii) in the event that I acquire a newly eligible dependent.

Signature of Employee		**Date of Waiver**	