Employer Group Use Only Please provide receipt date of form in this section when submitting on behalf of er	mployee/retiree.
Employer Group #: Employer Rece	ipt Date:
Authorized Rep:	
To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Fo	llowing Information
Employer or Union Name:	Group #:
LAST Name:	
FIRST Name:	Middle Initial: Sex: ☐ Male ☐ Female
Primary Phone Number: Secondary Phone Number:	Birth Date: (mm/dd/yyyy)
Are you a current or former member of any Kaiser Permanente Kaiser Peri health plan? Yes No If yes: Current Former	manente Medical/Health Record Number:
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experier considered your permanent residence address.):	ncing homelessness, a PO Box may be
City:	
County:	State: ZIP Code:
Mailing Address (only if different from your Permanent Residence Address) Street Address:	
City:	State: ZIP Code:
Email Address:	

Senior Advantage - Group - California	Page 2 of 6
Last Name	First Name
Please Provide Your Medicare Insurance Informa	tion
Please take out your red, white and blue Medicare card to complete this section.	Name (as it appears on your Medicare card):
 Fill out this information as it appears on your Medicare card. 	Medicare Number:
- OR -	Is Entitled To: Effective Date:
 Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 	HOSPITAL (Part A)
•	MEDICAL (Part B)
	You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.
Please Read and Answer These Important Questi	ons
1. Do you work?	work?
2. Are you the retiree?	
Name(s) of dependent(s):	loyer or union plan?
4. Will you have other prescription drug coverage (like VA, TF If "yes", please list your other coverage and your identifica Name of other coverage:	
5. Are you a resident in a long-term care facility, such as a nu If "yes", please provide the following information: Name of institution:	rsing home?
Address of institution (number and street):	Phone Number:
The state of the s	

Senior Advantage - Group - Californi	a	Page 3 of 6
Last Name	First Name	
6. Requested effective date of enrollment into this plan	n (subject to CMS approval):	
The fields in this section are optional		
Answering these questions is your choice. You can't	be denied coverage because you don't fill t	hem out.
Please check one of the boxes below if you would p or in an accessible format: ☐ Spanish ☐ Braille ☐ Large Print ☐ Audio C	_	guage other than English
Please contact Kaiser Permanente at 1-800-443-0815 if is listed above. Our office hours are 7 days a week, 8 a.m.	,	language other than what
Please complete the information below if you curre employer or union/trust fund. You must choose ONE coverage. Complete the information for that employer of	employer or union/trust fund from which to rec	•
Employer Group/Union/Trust Fund Name:		
Employer Group/Union/Trust Fund ID #:	Subgroup:	
Requested effective date of enrollment into this plan (s	ubject to CMS approval):	

Senior Advantage - Group - California		Page 4 of 6
Last Name	First Name	

Please Read and Sign Below FOR CALIFORNIA ENROLLEES ONLY:

KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however most employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage **Evidence of Coverage** document from Kaiser Permanente in order to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Last Name	First Name	
Release of Information:		
By joining this Medicare health plan, I acknowledge that the Medicother plans as necessary for treatment, payment and health care operelease my information including my prescription drug event data which follow all applicable Federal statutes and regulations. The information which follows all applicable federal statutes and regulations. The information including my provide false information including my provide false information.	erations. I also acto to Medicare, who ormation on this	cknowledge that Kaiser Permanente will may release it for research and other purposes enrollment form is correct to the best of my
I understand that my signature (or the signature of the person autilitie) on this application means that I have read and understand the individual (as described above), this signature certifies that: 1) this enrollment and 2) documentation of this authority is available upon	ne contents of thi person is author	s application. If signed by an authorized rized under State law to complete this
Enrollee or Authorized Representative Signature:		
Today's Date:		
If you are the authorized representative of the enrollee, meaning y enrollment request on their behalf under State law (Power of Attor and provide your information below:	•	• •
Name:		
Address:		
Phone Number: Relat	onship to Enro	llee:

Page 5 of 6

Senior Advantage - Group - California

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente – Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

Senior Advantage - Group - California		Page 6 of 6
Last Name	First Name	
For individuals helping enrollee with completing this form Complete this section if you're an individual (i.e. agents, broke an enrollee fill out this form. Do not complete this section if you	rs, SHIP counselors, far	
Name:		
Relationship to Enrollee:		
Signature:		
National Producer Number (Agents/Brokers only):		
Office Use Only:		
Name of staff member/agent/broker (if assisted in enrollmer	nt):	
Plan ID #:	Effective Date of	Coverage:
ICEP/IEP: OEP:	5	SEP (type):