



KAISER PERMANENTE®

VIRGINIA

**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

**ENROLLMENT & CHANGE FORM  
KAISER PERMANENTE FLEXIBLE CHOICE**

The Kaiser Permanente Physicians (HMO) benefits (Option 1) of Kaiser Permanente Flexible Choice are underwritten by KFHP-MAS. The Participating Provider (PPO) (Option 2) and Out-of-Network Providers (Indemnity) (Option 3) benefits of Kaiser Permanente Flexible Choice are underwritten by KPIC. **If you have any questions concerning the benefits and services that are provided by or excluded under your plan offering, please contact a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 before signing this form.**

**Please see instructions located at the back of this booklet for directions on how to complete this form. After you have completed this form, please sign and return all pages, including the instructions, to your employer's benefits office. DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.**

If you are enrolling in our Medicare product, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.

**TO BE COMPLETED BY EMPLOYER Please print or type in black ink only.**

**ENROLLMENT TYPE**

NEW  CHANGE

**EMPLOYMENT STATUS**

Active  Retired

**GROUP NO.**

**SUBGROUP NO.**

**EMPLOYEE LAST NAME**

**FIRST NAME**

**MI**

**SUFFIX**

*Check One and indicate date of event:*

New enrollment

New enrollment Effective Date (MM/DD/YYYY)

Open enrollment (complete sections A, C, F, G)

Open enrollment Effective Date (MM/DD/YYYY)

COBRA (complete sections A, B, E, G)

COBRA Effective Date (MM/DD/YYYY)

Loss of other coverage (complete sections A, C, F, G)

Cancel all coverage (empl. and family) (complete sections A, G)

Effective Date of Cancellation (MM/DD/YYYY)

**EMPLOYER AUTHORIZED REPRESENTATIVE SIGNATURE**

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

Printed or Typed Name/Title

Employer Signature

Date

Telephone

Fax





**IF MAKING A CHANGE, COMPLETE THE FOLLOWING:**

ADD DEPENDENTS (Complete sections A, C, F, G)

|   |   |  |                                      |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Birth <sup>++</sup>                                | Date of Event (MMDDYYYY)<br>□□□□□□□□                        | <input type="checkbox"/> Loss of other Coverage* | Date of Event (MMDDYYYY)<br>□□□□□□□□ |
| <input type="checkbox"/> Adoption*  | □□□□□□□□  | <input type="checkbox"/> Marriage*               | □□□□□□□□                             |
| <input type="checkbox"/> Address (complete sections A, G)                   | <input type="checkbox"/> Telephone (complete sections A, G) |  |                                      |
| <input type="checkbox"/> Name Change* _____                                 |   |  |                                      |
| Previous Name _____   |   |  |                                      |
| <input type="checkbox"/> Other (please specify; Complete sections A, C, G)* |   |  |                                      |

**C. FAMILY INFORMATION** (If additional space is needed please use another form and attach it to this form)

|  |                                 |                                 |  |
|--|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> ADD           | <input type="checkbox"/> DELETE | <input type="checkbox"/> SPOUSE | <input type="checkbox"/> DOMESTIC PARTNER<br>(If eligible under your plan) |
| LAST NAME                              | FIRST NAME                      | MI                              | SUFFIX   |
| □□□□□□□□□□□□□□                         | □□□□□□□□□□□□                    | □                               | □□□  |
| SOCIAL SECURITY NUMBER                 | MEDICAL RECORD NO.              | DATE OF BIRTH (MM/DD/YYYY)      | MALE FEMALE  |
| □□□□□□□□□□                             | □□□□□□□□□□                      | □□□□□□□□                        | □ □  |
| Primary Care Provider (PCP) Name _____ |                                 |                                 | PCP ID # □□□□□□  |

|  |                                 |                                |                                      |
|--|---------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> ADD           | <input type="checkbox"/> DELETE | <input type="checkbox"/> CHILD | <input type="checkbox"/> OTHER _____ |
| LAST NAME                              | FIRST NAME                      | MI                             | SUFFIX                               |
| □□□□□□□□□□□□□□                         | □□□□□□□□□□□□                    | □                              | □□□                                  |
| SOCIAL SECURITY NUMBER                 | MEDICAL RECORD NO.              | DATE OF BIRTH (MM/DD/YYYY)     | MALE FEMALE                          |
| □□□□□□□□□□                             | □□□□□□□□□□                      | □□□□□□□□                       | □ □                                  |
| Primary Care Provider (PCP) Name _____ |                                 |                                | PCP ID # □□□□□□                      |

|  |                                 |                                |                                      |
|--|---------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> ADD           | <input type="checkbox"/> DELETE | <input type="checkbox"/> CHILD | <input type="checkbox"/> OTHER _____ |
| LAST NAME                              | FIRST NAME                      | MI                             | SUFFIX                               |
| □□□□□□□□□□□□□□                         | □□□□□□□□□□□□                    | □                              | □□□                                  |
| SOCIAL SECURITY NUMBER                 | MEDICAL RECORD NO.              | DATE OF BIRTH (MM/DD/YYYY)     | MALE FEMALE                          |
| □□□□□□□□□□                             | □□□□□□□□□□                      | □□□□□□□□                       | □ □                                  |
| Primary Care Provider (PCP) Name _____ |                                 |                                | PCP ID # □□□□□□                      |

\*Additional documentation will be required.  
<sup>++</sup> May require additional information





**G. Important:** 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 contracts with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and Kaiser Permanente Insurance Company. I agree to be bound by those contracts. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

I authorize KFHP-MAS and 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.

**WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties may include imprisonment and/or fines. In addition, KFHP-MAS or KPIC may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

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  | Employer Signature | Date  |

\*Additional documentation will be required.

\*\* May require additional information





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 One Kaiser Plaza, Oakland, California

**ENROLLMENT & CHANGE FORM  
 KAISER PERMANENTE FLEXIBLE CHOICE  
 INSTRUCTIONS**

|   |  |
|---|--|
| <p>Welcome to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). We look forward to receiving your Enrollment and Change form. <b>If you have any question concerning the benefits and services that are provided by or excluded under these plan offerings, please contact a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 before signing this form.</b></p> <p>After you have completed this form, please sign and return it to your employer's benefits office. <b><u>DO NOT SEND THIS FORM TO KAISER PERMANENTE UNLESS OTHERWISE INSTRUCTED.</u></b></p> <p>If you are enrolling in Medicare, there is a separate enrollment process. Please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380 for more information.</p> | <p><b>Section B: Waiver of Coverage</b></p> <p>Complete this section if you voluntarily elect to waive all insurance coverage offered by your employer. You will also need to read and sign section G.</p>   |
| <p><b>How to Complete this form – Please Print</b></p> <p>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. <b>If you are electing to waive coverage, you only need to complete Sections A, B and sign in section G.</b> If you have any questions, contact your employer's benefits office.</p>  | <p><b>If Making a Change Section</b></p> <p>Complete this section if you are making a change (add or delete) to dependent status. If you are adding a dependent please complete sections A, C, F and G.</p>  |
| <p><b>To Be Completed by Employer</b></p> <p>Your employer will complete this section.</p> <p><b>Note:</b> The Kaiser Permanente Physicians (HMO) benefits (Option 1) of Kaiser Permanente Flexible Choice are underwritten by KFHP-MAS. The Participating Provider (PPO) (Option 2) and Out-of-Network Provider (Indemnity) (Option 3) benefits of Kaiser Permanente Flexible Choice are underwritten by KPIC.</p>   | <p><b>Section C: Family Information</b></p> <p>Make sure your dependents meet your group's eligibility guidelines. If you have any questions, contact your employer's benefits office. If you know the Medical record number, please provide it in the requested space. To select a primary care provider, please review the Kaiser Permanente Flexible Choice Provider Directory and enter the provider code of the primary care provider for you and each member of your family. The primary care provider must be listed in the KFHP-MAS portion of the Provider Directory. To obtain a directory please call a Member Services representative at (800) 777-7902 TTY Services: (301)-879-6380, or see our Web site at <a href="http://www.kaiserpermanente.org">http://www.kaiserpermanente.org</a></p> |
| <p><b>Section A: Employee Information</b></p> <p>Please provide information about yourself. To indicate your choice of primary care provider, please see the line at the end of the section.</p>  | <p><b>Section D: Maximum Age/Disabled Dependent</b></p> <p>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.</p>  |
| <p><b>Section E: Dependents residing at another PERMANENT address</b></p> <p>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.</p>   | <p><b>Section E: Dependents residing at another PERMANENT address</b></p> <p>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.</p>  |

**PLEASE INCLUDE THESE INSTRUCTIONS WHEN YOU SUBMIT THIS ENROLLMENT & CHANGE FORM**



|   |   |
|---|---|
| <p><b>Section F: Other Coverage Information</b></p>   | <p><b>Section G: Subscriber Sign-off</b></p>  |
| <p>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.</p> <p>If the Coordination of Benefits provisions apply to you, 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, Motor Vehicle Insurance (Except Virginia residents and Virginia group employees. Virginia residents and Virginia group employees are not subject to subrogation of a recovery for personal injuries from a third person.), 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, 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 (800) 777-7902 TTY Services: (301)-879-6380.</p> | <p>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 provider. Failure to complete all relevant parts of this form may delay or prevent enrollment and the issuance of a member ID card.</p> <hr/> <p style="text-align: center;"><b>MISREPRESENTATION</b></p> <p>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 which could subject you to civil and/or criminal penalties. <b>You may 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.</b></p> |

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