KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Oregon

Instructions

There are different types of plan and account changes you can make with this form. Please fill out your information in Section A. Next, 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're adding a new member, that won't automatically cancel any other coverage they have through the Health Insurance Marketplace or Kaiser Foundation Health Plan of the Northwest (KFHPNW). Don't want 2 plans? Be sure to end that other plan the day before the new plan starts to avoid paying 2 premiums or having a gap in coverage.

A. Fill out your information

Please select one: I'm the ☐ subscriber, ☐ spouse/domestic partner, or dependent child 18 and older, or ☐ parent or legal guardian

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Health record number (if any)

Social Security number (if any)

Phone

Home address (no P.O. boxes, please)

City

State

ZIP code

Billing address ☐ Check if the same as the home address.

City

State

ZIP code

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

B. What change(s) do you want to make?

Please check the boxes for the changes you wish to make, and on the next page, list each family member who is affected. If there are other members on your account who are not listed, we will not make any changes for them.

- ☐ I'm ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.
- ☐ I wish to change the subscriber.
- ☐ I wish to change the parent/legal guardian on a child-only account.
- ☐ I wish to end medical coverage for a family member.
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.
- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ I wish to change my address or phone number.
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)
- ☐ I wish to end adult dental coverage.
- ☐ I wish to end pediatric dental coverage.

For the following changes, please indicate when you are making the change in Section D and select your plan in Section E on page 3.

You can make the following change during open enrollment.

- ☐ I wish to change plans.

You can make the following changes during open enrollment or a special enrollment period.

- ☐ I wish to combine accounts.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to change plans within my metal tier (for example, from one Gold plan to another Gold plan) and everyone in my family listed on this form is eligible for a special enrollment period.
- ☐ I wish to add adult dental coverage (for members 19 and older). (Please select your plan in Section F.)
- ☐ I wish to add pediatric dental coverage (for members 18 and younger). (Please select your plan in Section G.)

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

If you have more than 3 dependents with a change, attach another form and complete just the information for those dependents.

Spouse/Domestic partner

☐ Add medical coverage ☐ End medical coverage
☐ Add adult dental coverage ☐ End adult dental coverage
☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Choose one: ☐ Spouse ☐ Domestic partner

Social Security number (if any) | Health record number (if any) | Date of birth (mm/dd/yyyy) | Gender: ☐ Male ☐ Female

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependent 1

☐ Add medical coverage ☐ End medical coverage
☐ Add adult dental coverage ☐ End adult dental coverage
☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) | Health record number (if any) | Date of birth (mm/dd/yyyy)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependent 2

☐ Add medical coverage ☐ End medical coverage
☐ Add adult dental coverage ☐ End adult dental coverage
☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) | Health record number (if any) | Date of birth (mm/dd/yyyy)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependent 3

☐ Add medical coverage ☐ End medical coverage
☐ Add adult dental coverage ☐ End adult dental coverage
☐ Add pediatric dental coverage ☐ End pediatric dental coverage

First name | MI | Last name | Gender: ☐ Male ☐ Female

Social Security number (if any) | Health record number (if any) | Date of birth (mm/dd/yyyy)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

D. When are you making a change?

Select one option: **A.** ☐ Open enrollment **B.** ☐ A special enrollment period

If **A.** Skip to Section E.

If **B.** Choose the life event that made you eligible for a special enrollment period:

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Child support order or other court order to cover a child
- ☐ Permanent relocation
- ☐ Change in eligibility for federal financial assistance through the Health Insurance Marketplace†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by the Health Insurance Marketplace

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Proof of eligibility is required. Please visit **kp.org/specialenrollment** or call **503-813-2000** or **1-800-813-2000** outside Portland for more information.

*If your qualifying life event is loss of KFHPNW coverage, we may review your prior membership records to establish eligibility.
†If you'll be getting federal financial assistance, don't use this form. We can help you apply at HealthCare.gov.

E. Choose your health plan

To be eligible for KFHPNW coverage, you or any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B. If you indicated that you would like to change plans during open enrollment or add medical coverage for a family member, please select the plan you would like. Each family member you listed in Section C will be moved into the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan.

- ☐ KP OR Bronze 6550/0% HSA
- ☐ KP OR Standard Bronze Plan
- ☐ KP OR Bronze 5000/50
- ☐ KP OR Standard Silver Plan
- ☐ KP OR Silver 3500/30
- ☐ KP OR Silver 3000/20% HSA
- ☐ KP OR Silver 2500/30
- ☐ KP OR Standard Gold Plan
- ☐ KP OR Gold 1000/20
- ☐ KP OR Gold 0/20
- ☐ KP OR Catastrophic 7900/0‡

‡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 **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

F. Choose your dental plan

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

- ☐ KP OR Dental 100
- ☐ KP OR Dental 80H
- ☐ KP OR Dental 80L

G. Choose your required pediatric dental plan

If you enroll in a KFHPNW plan, then by law you must also enroll in a separate pediatric dental plan. Or, if you already have other pediatric dental coverage that is certified by the Health Insurance Marketplace, you must let us know.

If you want to add pediatric dental coverage, please choose your plan:

- ☐ KP OR Dental 100
- ☐ KP OR Dental 80H
- ☐ KP OR Dental 80L
- ☐ I have bought separate pediatric dental coverage certified by the Health Insurance Marketplace for everyone on this form.

H. Sign the form

I understand that it may be 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 my policy. I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B.

For all account and plan changes, the subscriber and all dependents 18 and older making a change must sign. If there are more than 3 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

X _____ Date (mm/dd/yyyy) __/__/____

Subscriber/new subscriber (parent or legal guardian for subscribers under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

Contact information

Mail to: Kaiser Permanente P.O. Box 203007 Denver, CO 80220-9007	**Or fax toll free to:** Membership Administration **1-866-846-2650**	**Questions? Call** **503-813-2000** or **1-800-813-2000** outside Portland

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232.

Print

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Northwest (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 **1-800-813-2000** (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: Member Relations, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232, telephone number: 1-800-813-2000.

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 **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (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 **1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (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。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

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 **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).