KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Colorado

Instructions

- You may use this form to make plan changes or account changes to an existing Kaiser Permanente for Individuals and Families (KPIF) account. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- There are different types of plan changes and account changes you can make with this form. Please fill out your personal information in Section A. Then 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 are a subscriber ending coverage, your dependents' coverage automatically ends, and they have a special enrollment period to enroll in new coverage. You may choose to keep your children under 21 years of age on a child-only account.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. To avoid paying for 2 plans or having a gap in coverage, please cancel any other coverage they have as of the day before their new coverage starts.
- Note: If you're entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to change KPIF plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF plan as a new dependent.

A. Fill out your information

If you're making a change, please update the boxes below with your new information.

First name | MI | Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) ☐☐☐ - ☐☐ - ☐☐☐☐

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

City

State | ZIP code | County | Phone (mobile phone if available) ☐☐☐ - ☐☐☐ - ☐☐☐☐

Mailing address ☐ Check if same as home address

City

State | ZIP code

Email address

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 below for the changes you wish to make and list each family member affected. We won't make any changes for any family members you don't list.

You can make the following changes during open enrollment or a special enrollment period. To make a change other than listed below, you can call Member Services at **1-800-632-9700** (TTY **711**).

- ☐ I wish to change plans.
- ☐ I wish to add medical coverage for a family member.
- ☐ I want to change my child-only account to a family account with myself as the subscriber.

(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

Combine Accounts

Accounts can be combined during open enrollment or a special enrollment period.

☐ I wish to add (a) family member(s) that is already on a Kaiser Permanente plan to my account. Doing this will end their existing plan. (Please indicate which family member(s) will move to your account in Section C.).

Account Ending

First name | MI

Last name

Subscriber medical record number for account ending

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

Subscriber or parent/legal guardian for account ending

You can make the following changes any time during the year. *(Note: For these changes, you can skip Sections D and E.)*

- ☐ I wish to end all coverage for myself and all family members.
- ☐ I wish to end all coverage for a family member.
- ☐ I wish to end my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ I wish to end my and my spouse's/civil union partner's coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)

Requested effective date (not guaranteed) __/__/____ (mm/dd/yyyy)

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

Spouse/civil union partner

☐ Name change ☐ Add medical coverage ☐ End medical coverage

First name | MI | Choose one: ☐ Spouse ☐ Civil union partner

Last name

Date of birth (mm/dd/yyyy) __/__/____ | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) ___-___-____

Medical record number (if any)

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

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

Dependent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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

☐ Name change ☐ Add medical coverage ☐ End medical coverage

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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

☐ Name change ☐ Add medical coverage ☐ End medical coverage

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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. Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Section E)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 30 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-255-5169** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or civil union partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Initial confirmation of pregnancy by a health care practitioner
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The first day of the month in which pregnancy is confirmed**
  - ☐ The first day of the month after we receive the form
- ☐ Permanent relocation with access to new plans
- ☐ Determination by Department of Insurance Commissioner of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums
- ☐ Loss of short-term health coverage
- ☐ Release from incarceration
- ☐ Change in income changing your eligibility for federal financial assistance through Connect for Health Colorado
- ☐ Determination by Connect for Health Colorado of exceptional circumstances
- ☐ Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee

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

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.
**If you choose to have your coverage start on the first day of the month in which pregnancy is confirmed, you will be required to pay the monthly premiums retroactively for those additional months of coverage, and only services received in-network will be retroactively covered.

E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Choosing a health plan is based on your county. See the county list below to determine which health plans are available to you. Each family member you listed in Section C will be moved to the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan. Your county may appear multiple times.

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park, and Teller

Plans available:

- ☐ KP Select CO Bronze 6500/50
- ☐ KP Select CO Bronze 6500/35%/HSA
- ☐ KP Select CO Bronze 7500/60 RX Copay
- ☐ KP Select CO Bronze 8500/50
- ☐ KP Select CO Catastrophic*
- ☐ KP Select CO Silver 2200/25 X
- ☐ KP Select CO Silver 4500/30 RX Copay X
- ☐ KP Select CO Silver 3700/20%/HSA X
- ☐ KP Select CO Silver 4000/25 X
- ☐ KP Select CO Silver 5500/25 X
- ☐ KP Select CO Gold 0/25 RX Copay
- ☐ KP Select CO Gold 1500/20
- ☐ KP Select CO Gold 2000/20

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, and Weld

Plans available:

- ☐ KP CO Bronze 6500/50
- ☐ KP CO Bronze 6500/35%/HSA
- ☐ KP CO Bronze 7500/60 RX Copay
- ☐ KP CO Bronze 8500/50
- ☐ KP CO Catastrophic*
- ☐ KP CO Silver 2200/25 X
- ☐ KP CO Silver 4500/30 RX Copay X
- ☐ KP CO Silver 3700/20%/HSA X
- ☐ KP CO Silver 4000/25 X
- ☐ KP CO Silver 5500/25 X
- ☐ KP CO Gold 0/25 RX Copay
- ☐ KP CO Gold 1500/20
- ☐ KP CO Gold 2000/20

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld

Plans available:

- ☐ KP Colorado Option Bronze
- ☐ KP Colorado Option Silver X
- ☐ KP Colorado Option Gold

***For applicants under 30 or with hardship exemptions**

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

The Kaiser Permanente Catastrophic plan does not include pediatric dental benefits. If you are applying for this plan and have children under age 19 who will be covered, you must purchase pediatric dental coverage separately.

- ☐ I do not have children under age 19 who will be covered under this plan.
- ☐ I hereby attest that I have or will purchase pediatric dental essential health benefit (EHB) coverage.

X _____

Applicant's signature

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-632-9700** (TTY **711**), or contact your broker.

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

F. Sign the form

- If a broker has assisted you with this account/plan change, by signing below, you are giving permission to that broker to act on your behalf regarding this account/plan change.
- If I worked with a broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $18 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- I understand that Kaiser Permanente will rely on the information provided in this form. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Permanente may choose to terminate coverage back to the coverage effective date.
- I verify that no one listed on this form who is changing plans or being added as a dependent is entitled to Medicare Part A or enrolled in Medicare Part B.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

Note: The subscriber making a change must sign the form.

X _____ Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

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

Contact information

Mail to: Kaiser Permanente P.O. Box 23127 San Diego, CA 92193	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-800-632-9700** (TTY **711**)

All plans are offered and underwritten by Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (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 **1-800-632-9700** (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 at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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**, (TTY **1-800-537-7697**). Complaint forms are available at **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 **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (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 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (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。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

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 **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).