

## Proof of qualifying life event form

 <p><b>Who should use this form?</b></p>	<ul style="list-style-type: none"> <li>• A qualifying life event is a change in your life that lets you apply for health care coverage outside the annual open enrollment period. This is called a special enrollment period. Examples include getting married, moving to a Kaiser Permanente service area with access to new health plans, or losing coverage because you lost your job.</li> <li>• Use this Proof of Qualifying Life Event Form to submit your proof when applying directly to Kaiser Permanente if you or a dependent had a qualifying life event. You may also use this form to submit your proof when applying to your state's health benefit exchange in Colorado or Washington. For all other exchange applications, check your state's exchange for information on how to submit proof for exchange plans. It can help you figure out which type of proof you'll need to provide for your qualifying life event.             <ul style="list-style-type: none"> <li>◦ <b>Kaiser Permanente for Individuals and Families (KPIF) plan members</b> should submit their proof along with the Account Change Form.</li> <li>◦ <b>People who aren't Kaiser Permanente for Individuals and Families (KPIF) plan members</b> should submit their proof along with their Application for health coverage.</li> </ul> </li> </ul>
 <p><b>Who should not use this form?</b></p>	<ul style="list-style-type: none"> <li>• If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Visit <a href="https://kp.org/medicare">kp.org/medicare</a> to learn more about your Medicare plan options or to apply for Medicare coverage.</li> </ul>
 <p><b>How to use this form</b> California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington</p>	<ul style="list-style-type: none"> <li>• Fill out Steps 1, 2, and 3.</li> <li>• Submit this form and proof of your qualifying life event with your application or Account Change Form (if applicable). See "Submitting your proof" on page 16 for details.</li> </ul>
 <p><b>When to submit your proof</b> California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington</p>	<p>You have a limited period of time to submit your proof. Visit <a href="https://kp.org/specialenrollment">kp.org/specialenrollment</a> for details and deadlines.</p> <p>If we don't get your proof in time, we'll have to cancel your application or account change request. You may apply again if your special enrollment period is still in effect.</p> <p>For applications submitted on <a href="https://buykp.org">buykp.org</a>, submit your proof online.</p>
 <p><b>Need help?</b></p>	<p>Visit <a href="https://kp.org/specialenrollment">kp.org/specialenrollment</a> for a comprehensive qualifying life event list. You can also call us at <b>1-800-494-5314 (TTY 711)</b>, or contact your broker/producer or Kaiser Permanente representative.</p>

Primary applicant name

## STEP 1: Primary applicant information

### Who is the primary applicant?

- In an individual plan, the primary applicant is the person who'll be covered by the health plan.
- In a family plan, the primary applicant is the family member on the health plan who's authorized to make changes to the account.
- In a child-only plan (where offered) for a child under 18, the child is the primary applicant.

**Please note:** This isn't an application for health care coverage. To get health care coverage, you need to submit an application or Account Change Form.

First name

MI

Date of birth (mm/dd/yyyy)

Last name

Phone (mobile phone if available)

Application ID number (if you applied online)

Social Security number (if any)

Medical record number (if any)

Home address (no P.O. boxes)

City

State

ZIP code

Parent/legal guardian (if primary applicant is under 18)

First name

Last name

Broker/producer or Kaiser Permanente representative (if any)

First name

Last name

## STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying event (mm/dd/yyyy)

For loss of minimum essential health coverage, the date of the qualifying event is the last full day you were covered under your prior plan.

Primary applicant name

### STEP 3: Proof of your qualifying life event

- Check one box for your qualifying life event and one box for the proof you're sending (unless otherwise noted). Make sure the qualifying event and the type of proof apply to your state.
- Send one type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
  - First and last name
  - Home address (no P.O. boxes)
  - Medical record number (if any)
  - Date of birth

Qualifying life event	Type of proof
<p><input type="checkbox"/> <b>1. Loss of minimum essential health coverage</b> California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†</p> <p><b>Important: This is NOT a qualifying life event if:</b></p> <ul style="list-style-type: none"><li>• You're losing coverage because you didn't pay your premiums.</li><li>• Your plan was rescinded.</li><li>• You had Medicare Part B coverage and don't have any other coverage.</li><li>• You voluntarily ended your coverage.</li><li>• You had temporary or short-term coverage like traveler's insurance.</li></ul>	<p><b>From your employer</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Letter or other document from your employer stating the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date this coverage ended or will end.</li><li><input type="checkbox"/> Letter or document from your employer stating the employer stopped or will stop contributing to the cost of coverage and the date this contribution ended or will end.</li><li><input type="checkbox"/> Pay stubs of current and previous hours if you lost coverage because of a reduction in work hours.</li><li><input type="checkbox"/> Letter or document that indicates your coverage is ending due to age.</li></ul> <hr/> <p><b>From COBRA</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Letter showing your employer's offer of COBRA coverage or stating when your COBRA coverage ended or will end. We must receive your application within 60 days of the date when your COBRA coverage will end as stated on your proof.</li><li><input type="checkbox"/> Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end.</li></ul> <hr/> <p><b>From your carrier or Medicaid, Medi-Cal, Medicare, or other government programs</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Letter from your carrier showing a coverage end date.</li><li><input type="checkbox"/> Letter or notice from Medicaid, Medi-Cal, or the Children's Health Insurance Program (CHIP) stating when Medicaid, Medi-Cal, or CHIP coverage ended or will end.</li><li><input type="checkbox"/> Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end.</li></ul>

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><b>Loss of minimum essential health coverage</b> <i>(continued)</i></p> <p>California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington<sup>†</sup></p>	<p><b>Other loss of coverage (including individual coverage)</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Letter from your student health plan indicating when student health coverage ended or will end.</li><li><input type="checkbox"/> Letter or other document from Social Security office stating that the person who covers you on their health plan is entitled to Medicare.</li><li><input type="checkbox"/> Letter or other document from an employer stating that the person who covers you on their health plan is starting new employer coverage.</li><li><input type="checkbox"/> Dated military discharge papers or Certificate of Release, including the date coverage ended or will end, if you're losing coverage because you're no longer on active military duty.</li><li><input type="checkbox"/> Dated and signed written verification from a broker/producer or Kaiser Permanente representative, or dated letter from the carrier, if you are or were enrolled in a non-calendar-year plan that's ending, including the date the plan ended.</li></ul>
<p><b>Loss of minimum essential health coverage</b> <i>(continued)</i></p> <p>Colorado</p> <p><b>Important: This is NOT a qualifying life event if:</b></p> <ul style="list-style-type: none"><li>• You're losing coverage because you didn't pay your premiums.</li><li>• Your plan was rescinded.</li><li>• You had Medicare Part B coverage and don't have any other coverage.</li><li>• You voluntarily ended your coverage.</li></ul>	<p>No proof required with your application.</p>
<p><input type="checkbox"/> <b>2. Loss of pregnancy related coverage or loss of access to health care services through coverage provided to a pregnant woman's unborn child</b></p> <p>Maryland</p>	<p><input type="checkbox"/> Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.</p>

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<input type="checkbox"/> <b>3. Loss of medically needy coverage</b> Maryland	<input type="checkbox"/> Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.
<input type="checkbox"/> <b>4. Enrollment in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA)</b> Maryland	<input type="checkbox"/> Dated and signed written verification from an agent/broker/producer or dated letter from the carrier, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended.
<b>5. Gaining, becoming, or losing a dependent, or death of a subscriber or a dependent</b>  <input type="checkbox"/> <b>5a. Gaining or becoming a dependent through marriage</b>  <b>Check 2 boxes total.</b> District of Columbia, Virginia  This event requires proof of prior coverage. Visit <a href="http://kp.org/specialenrollment">kp.org/specialenrollment</a> for more information.	<b>Provide one of these:</b> Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): <ul style="list-style-type: none"><li><input type="checkbox"/> Paid premium invoice proving coverage within the last 60 days.</li><li><input type="checkbox"/> Employer benefit record proving coverage within the last 60 days.</li></ul> <b>And provide one of these:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Marriage certificate/license showing the date of the marriage.</li><li><input type="checkbox"/> Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.</li></ul>
<input type="checkbox"/> <b>5b. Gaining or becoming a dependent through marriage or domestic partnership registration</b>  <b>Check 2 boxes total.</b> California, Georgia, Hawaii, Maryland, Oregon, Washington†  This event requires proof of prior coverage. Visit <a href="http://kp.org/specialenrollment">kp.org/specialenrollment</a> for more information.	<b>Provide one of these:</b> Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): <ul style="list-style-type: none"><li><input type="checkbox"/> Paid premium invoice proving coverage within the last 60 days.</li><li><input type="checkbox"/> Employer benefit record proving coverage within the last 60 days.</li></ul> <b>And provide:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Marriage certificate/license showing the date of the marriage.</li><li><input type="checkbox"/> Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.</li><li><input type="checkbox"/> Official government record, including date of domestic partnership registration.</li></ul>

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Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><input type="checkbox"/> <b>5c. Gaining or becoming a dependent through marriage or civil union partnership</b></p> <p><b>Check 2 boxes total.</b></p> <p>Colorado†</p> <p>This event requires proof of prior coverage. Visit <a href="http://kp.org/specialenrollment">kp.org/specialenrollment</a> for more information.</p>	<p><b>Provide one of these:</b></p> <p>Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only):</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Paid premium invoice proving coverage within the last 60 days.</li><li><input type="checkbox"/> Employer benefit record proving coverage within the last 60 days.</li></ul> <p><b>If you can't provide proof of minimum essential coverage, you may send in one of the following:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Official documentation showing that you are an American Indian or Native Alaskan.</li><li><input type="checkbox"/> Proof that you lived for one or more days during the 60 days before your life event or during your most recent open enrollment period in a service area where no qualified health plan was available through your state's health benefit exchange. You can provide a screenshot from the exchange website or other proof from the exchange.</li><li><input type="checkbox"/> Proof that you lived outside of the United States or in a United States territory for one or more days during the 60 days before the date of the qualifying life event.</li></ul> <p><b>And provide one of these:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Marriage certificate/license/other documentation showing the date of the marriage.</li><li><input type="checkbox"/> Official government record, including date of civil union.</li></ul>
<p><input type="checkbox"/> <b>5d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care</b></p> <p>California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†</p>	<p><b>Birth of a child</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Birth certificate or application for a birth certificate for the child.</li><li><input type="checkbox"/> Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth.</li><li><input type="checkbox"/> Military record showing the child's birth date and place of birth.</li><li><input type="checkbox"/> Official government record of a foreign birth certificate showing the child's birth date and place of birth.</li><li><input type="checkbox"/> Religious record showing the child's birth date and place of birth.</li><li><input type="checkbox"/> Letter or other document from the carrier, like an Explanation of Benefits, showing that services related to birth or after-birth care were given to the child, the mother, or both, including the dates of service.</li></ul> <p><b>Adoption or foster care</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Adoption letter or record showing date of adoption, dated and signed by a court official.</li><li><input type="checkbox"/> Court order showing when the order started. It must have a filing date stamp.</li><li><input type="checkbox"/> Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth.</li><li><input type="checkbox"/> U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions.</li><li><input type="checkbox"/> Medical support court order. It must have a court filing date stamp.</li><li><input type="checkbox"/> Foster care papers dated and signed by a court official.</li></ul>

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Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<b>5d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care</b> <i>(continued)</i> Colorado†	<b>Birth of a child</b> <input type="checkbox"/> Birth certificate or application for a birth certificate for the child. <b>Adoption or foster care</b> <input type="checkbox"/> Adoption letter or record showing date of adoption, dated and signed by a court official. <input type="checkbox"/> Court order showing when the order started. It must have a court filing date stamp. <input type="checkbox"/> Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. <input type="checkbox"/> U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. <input type="checkbox"/> Medical support court order. It must have a court filing date stamp. <input type="checkbox"/> Foster care papers dated and signed by a court official.
<input type="checkbox"/> <b>5e. Losing a dependent through divorce, dissolution of domestic partnership, or legal separation</b> California, Maryland	<input type="checkbox"/> Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
<input type="checkbox"/> <b>5f. Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation</b> Colorado†	<input type="checkbox"/> Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
<input type="checkbox"/> <b>5g. Death of the subscriber or a dependent</b> California, Maryland	<input type="checkbox"/> Death certificate.
Colorado†	<input type="checkbox"/> Death certificate or obituary.
<input type="checkbox"/> <b>6. Child support order or other court order to cover a dependent</b> California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	<input type="checkbox"/> Signed court order with court filing date stamp.
Colorado†	<input type="checkbox"/> Signed court order with court filing date stamp or dated Designated Beneficiary Agreement.

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Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><input type="checkbox"/> <b>7. Permanent relocation with access to new plans</b> California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†</p> <p>Choose <b>Permanent relocation with access to new plans</b>, if one of the following applies to you:</p> <ul style="list-style-type: none"><li>• You moved from a non-Kaiser Permanente area to a Kaiser Permanente area.</li><li>• You moved to a new state.</li><li>• You moved from a foreign country or a United States territory.</li><li>• You moved from a county that did not offer a qualified health plan.</li></ul> <p>This event requires proof of prior coverage. Visit <b><a href="http://kp.org/specialenrollment">kp.org/specialenrollment</a></b> for more information.</p>	<p><b>If you have permanently relocated (moved) to the United States from another country</b> <b>Send the following:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Signed naturalization papers, green card, education certificate, or visa dated within the last 60 days.</li></ul> <p><b>If you have permanently relocated (moved) within the United States</b> <b>Send a total of three pieces:</b></p> <p><b>1) One of the following proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Paid premium invoice proving coverage within the last 60 days.</li><li><input type="checkbox"/> Employer benefit record proving coverage within the last 60 days.</li></ul> <p><b>2 and 3) Within 60 days of your move: one of the following items showing your previous address and one showing your current address (no P.O. Boxes):</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Lease or rental agreement.</li><li><input type="checkbox"/> Insurance documents, like homeowner's, renter's, or life insurance policy or statement.</li><li><input type="checkbox"/> Mortgage deed, if it states the owner uses the property as the primary residence.</li><li><input type="checkbox"/> Mortgage or rental payment receipt.</li><li><input type="checkbox"/> Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card.</li><li><input type="checkbox"/> Mail from a government agency to your address, like a Social Security statement, or a notice from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program.</li><li><input type="checkbox"/> Your valid state ID.</li><li><input type="checkbox"/> Internet, cable, or other utility bill (including any public utility like a gas or water bill) or other confirmation of service (including a utility hookup or work order).</li><li><input type="checkbox"/> Telephone bill showing your address (cellphone or wireless bills are OK).</li><li><input type="checkbox"/> Mail from a financial institution, like a bank statement.</li><li><input type="checkbox"/> U.S. Postal Service change of address confirmation letter.</li><li><input type="checkbox"/> Pay stub showing your address.</li><li><input type="checkbox"/> Voter registration card showing your name and address.</li><li><input type="checkbox"/> Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.</li></ul>

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Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><b>Permanent relocation with access to new plans</b> <i>(continued)</i> Colorado</p> <p>Choose <b>Permanent relocation with access to new plans</b>, if one of the following applies to you:</p> <ul style="list-style-type: none"><li>• You moved from a non-Kaiser Permanente area to a Kaiser Permanente area.</li><li>• You moved to a new residence within our Kaiser Permanente service area where your current health plan is not available or you have additional health plan options.</li><li>• You moved to a new state.</li><li>• You moved from a foreign country or a United States territory.</li><li>• You moved from a county that did not offer a qualified health plan.</li></ul>	<p>No proof required with your application.</p>

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><input type="checkbox"/> <b>8. Changes in employer health coverage making you eligible for a premium tax credit</b> California, Georgia, Hawaii, Oregon, Colorado<sup>†</sup>, District of Columbia, Maryland, Virginia, Washington<sup>†</sup></p> <p>You must apply through your state's health benefit exchange</p> <p>You're now eligible for a premium tax credit because your coverage through your employer has changed.</p>	<p><input type="checkbox"/> Letter from employer stating change in minimum essential health coverage and showing determination date.</p> <p><input type="checkbox"/> Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.</p>
<p><input type="checkbox"/> <b>9. Determination by your state's health benefit exchange of exceptional circumstances</b> California, Colorado<sup>†</sup>, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington<sup>†</sup></p>	<p><input type="checkbox"/> Letter or notice from your state's health benefit exchange stating you're eligible for a special enrollment period and showing determination date.</p>
<p><input type="checkbox"/> <b>10. Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)</b> California, Colorado<sup>†</sup>, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington<sup>†</sup></p>	<p><input type="checkbox"/> Letter or other documentation stating you are now eligible to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) including the date showing when you are first eligible for the ICHRA or QSEHRA.</p>

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<input type="checkbox"/> <b>11. Domestic violence or spousal abandonment occurring within the household</b> California, Colorado <sup>†</sup> , District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington <sup>†</sup>	<input type="checkbox"/> Attestation stating you're a victim of domestic abuse or spousal abandonment.
<input type="checkbox"/> <b>12. Discontinuation of employer contribution or government subsidization of COBRA premiums</b> California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington <sup>†</sup>	<input type="checkbox"/> Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end.
Colorado	No proof required with your application.
<input type="checkbox"/> <b>13. Release from incarceration</b> California, Colorado	No proof required with your application.
District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	If you were recently released from incarceration (jail), you'll have to apply through your state's health benefit exchange. No proof is required.
<input type="checkbox"/> <b>14. Misinformation about your enrollment in minimum essential coverage</b> California	<input type="checkbox"/> Notice from your state's health benefit exchange or the Department of Managed Health Care stating you're eligible for a special enrollment period and showing determination date.
<input type="checkbox"/> <b>15. Provider network changes</b> California	<input type="checkbox"/> Notice that the provider is no longer participating in the health benefit plan and showing determination date.

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<input type="checkbox"/> <b>16. Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee</b> California	<input type="checkbox"/> Written confirmation, with date, from the Department of Managed Health Care that the health plan in which you're enrolled has substantially violated a material provision of your contract.
Colorado	No proof required with your application.
Maryland	<input type="checkbox"/> Written confirmation, with date, from the Maryland Insurance Administration that the health plan in which you're enrolled has substantially violated a material provision of your contract.
<input type="checkbox"/> <b>17. Eligibility for app-based transportation or delivery network company health care stipend</b> California	<input type="checkbox"/> A copy or a screen shot of your quarterly hours driven.
<input type="checkbox"/> <b>18. Determination by the Department of Insurance Commissioner of exceptional circumstances</b> Colorado <sup>†</sup>	<input type="checkbox"/> Letter or notice from the Department of Insurance Commissioner stating you're eligible for a special enrollment period and showing determination date.
<input type="checkbox"/> <b>19. Loss of Short Term Health Coverage</b> Colorado	No proof required with your application.
<input type="checkbox"/> <b>20. Initial confirmation of pregnancy by a health care practitioner</b> Maryland	<input type="checkbox"/> Document from your health care provider confirming your initial pregnancy. You have 90 days from the time your pregnancy is confirmed to enroll.
Colorado <sup>†</sup>	<input type="checkbox"/> Document from your health care provider confirming your initial pregnancy.

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<input type="checkbox"/> <b>21. Change in employer health coverage making you ineligible for a premium tax credit or change in eligibility for cost share reductions</b> Maryland	<input type="checkbox"/> Letter from employer stating change in minimum essential health coverage and showing determination date. <input type="checkbox"/> Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.
<input type="checkbox"/> <b>22. Tax Season Easy Enrollment</b> Maryland  You must apply through your state's health benefit exchange.	Your financial information has been validated by the Comptroller, and you don't need to send additional proof.
<input type="checkbox"/> <b>23. Easy Enrollment for Unemployment Insurance Claimants</b> Maryland  You must apply through your state's health benefit exchange.	If you received a letter from Maryland Health Connection stating you preliminarily qualified for health care coverage. Your financial information has been validated by the Maryland Health Connection and you don't need to send additional proof.
<input type="checkbox"/> <b>24. Change in immigration status</b> California, Colorado <sup>†</sup> , District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington <sup>†</sup>  You must apply through your state's health benefit exchange.	<input type="checkbox"/> Official documentation of a change in citizenship or immigration status.

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

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### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<p><input type="checkbox"/> <b>25. Coverage as American Indian/Native Alaskan</b> California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington<sup>†</sup></p> <p>You must apply through your state's health benefit exchange.</p>	<p><input type="checkbox"/> Official documentation showing your status.</p>
Colorado	No proof required with your application.
<p><input type="checkbox"/> <b>26. Change in income changing your eligibility for federal financial assistance</b> California, Colorado<sup>†</sup>, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington<sup>†</sup></p> <p>You must apply through your state's health benefit exchange.</p>	<p><b>Provide one of these:</b> Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days.</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Paid premium invoice proving coverage within the last 60 days.</li><li><input type="checkbox"/> Employer benefit record proving coverage within the last 60 days.</li></ul> <p><b>And provide:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Most recent eligibility determination from your state's health benefit exchange showing determination date.</li></ul>
<p><input type="checkbox"/> <b>27. Monthly Special Enrollment Period (SEP) for low-income subscribers</b> California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Virginia</p> <p>You must apply through your state's health benefit exchange.</p>	<p>If your income falls below 150% of the federal poverty level qualifying you for a monthly special enrollment period, no proof is required.</p>
Washington	If your income falls below 250% of the federal poverty level, your state's exchange will determine if you qualify for a monthly special enrollment period and will let you know what, if any, proof is required.

<sup>†</sup>In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

### STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
<input type="checkbox"/> <b>28. Tax Time Enrollment</b> Colorado	Your financial information has been validated through your tax filing and Connect for Health Colorado and you don't need to send additional proof.
<input type="checkbox"/> <b>29. Paid penalty for not having health coverage</b> California  You must apply through your state's health benefit exchange.	If you paid the Individual Shared Responsibility Penalty to California's Franchise Tax Board within the last 60 days, no proof is required.
<input type="checkbox"/> <b>30. Being potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and being determined ineligible after open enrollment has ended or more than 60 days after the qualifying event</b> Maryland	<input type="checkbox"/> Letter or notice from Medicaid or Children's Health Insurance Program (CHIP), with date, stating that you are ineligible for coverage.

## Submitting your proof

### How are you applying?

- **If you're applying online:** Sign in at [kp.org/apply](https://kp.org/apply) and upload your proof. You don't need to upload this form.
- **If you're applying by mail or fax:** Use the information on this page to send your proof and this form to the address or fax number below.
- **If you're applying through the health benefit exchange:** The health benefit exchange may require submission of proof.

### Send application or Account Change Form and proof along with this form:

#### By mail

Kaiser Permanente for Individuals and Families  
P.O. Box 23127  
San Diego, CA 92193-9921

#### By fax

1-855-355-5334

**To download an Account Change Form, visit [kp.org/specialenrollment](https://kp.org/specialenrollment).**

**By submitting a signed application or Account Change Form and proof of your qualifying life event, you're saying that the qualifying life event happened. It's important that we get proof of your qualifying life event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we determine that the qualifying life event didn't happen, or we learn of any other inaccuracy in the information that is included in the application, Account Change Form or any other information that you submit, we may take legal action. The legal action may include but is not limited to canceling your coverage retroactively to the day it started. You may also be responsible for the full charges of any services that you received.**

In California, KFHP plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612 • In Colorado, all plans are offered and underwritten by Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247 • In Georgia, all plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Rd. NE, Atlanta, GA 30305 • In Hawaii, all plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813 • In Oregon and southwest Washington (Clark and Cowlitz counties), all plans are offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • In Washington (except Clark, Cowlitz, and certain other counties), all plans are offered and underwritten by Kaiser Foundation Health Plan of Washington, 2715 Naches Ave. SW, Renton, WA 98057 • In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852.