KAISER PERMANENTE CHOICE SOLUTION

A *CHOICE* Administrators® Program

www.kpchoicesolution.com

PLEASE PRINT USING BLACK OR BLUE INK

RENEWAL
Change Request Form

Fax completed form to (800) 566-8514 or for assistance call (800) 580-9626

1 Employee Information

Employee Last Name

Employee Social Security Number

Employee First Name

Middle Initial

Group #

Street Address

Apt. #

City

State

Zip Code

Home Telephone ( )

Company Name

Address listed is: ☐ Residential Address ☐ Mailing Address | ☐ Check here if new address

2 Adding/Cancelling A Spouse/Domestic Partner/Dependent

REASON FOR CANCELLATION:

COMPLETE THIS SECTION TO ADD/CANCEL DEPENDENT COVERAGE. IF ADDING DEPENDENTS AGE 19 TO 24, PLEASE COMPLETE STUDENT VERIFICATION FORM.

	Coverage Type	Last Name	First Name	Sex	Social Security Number	Birth Date (Month/Day/Year)	Full Time Student?	Dependent Disabled?
EMPLOYEE ❑ Cancel	❑ Medical ❑ Dental			❑ Male ❑ Female	— —	/ /		
❑ Spouse OR ❑ Domestic Partner ❑ Add† ❑ Cancel	❑ Medical ❑ Dental			❑ Male ❑ Female	— —	/ /		
CHILDREN ❑ Add† ❑ Cancel	❑ Medical ❑ Dental		❑ Child ❑ Grandchild*	❑ Male ❑ Female	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No
❑ Add† ❑ Cancel	❑ Medical ❑ Dental		❑ Child ❑ Grandchild*	❑ Male ❑ Female	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No
❑ Add† ❑ Cancel	❑ Medical ❑ Dental		❑ Child ❑ Grandchild*	❑ Male ❑ Female	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No

NOTE: If Last Name of spouse/child(ren) is different from Employee's Last Name, please give brief explanation:

*Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

†As I am adding my dependent(s), and by signing this document <u>I declare under the penalty of perjury</u> under the laws of the state of California that the following statements are true and correct regarding the above <u>enrolling dependents</u>, as applicable:

My spouse and I are legally married as recognized by the state of California.

My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.

My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

<u>I understand</u> that I may be asked for legal proof of the above at any time.

<u>I understand</u> that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

<u>I understand</u> that any persons, business, or health plan that suffers a loss because of false declarations contained in this statement may have cause to bring civil action against me to recover their losses.

3 Medical Benefit Design Change/Add

*INDICATE **NEW** BENEFIT DESIGN YOU ARE REQUESTING:*

(CHECK ONE) ❑ **ADD** ❑ **CHANGE**

❑ **HMO 10** ❑ **HMO 30** ❑ **HMO 20/$1,000** ❑ **HDHP 1900*** ❑ **HDHP 2700***

❑ **POS 20/$1,000** ❑ **POS 30/$1,500** ❑ **PPO 30/$500** ❑ **PPO HSA 2200*** ❑ **Indemnity**

**HSA-Qualified High Deductible Health Plan* (*)

4 Dental Benefit Design Change/Add

(CHECK ONE) ❑ **ADD** ❑ **CHANGE**

❑ **DHMO 200†** ❑ **PPO 1000** ❑ **FFS 1000**

❑ **DHMO 250†** ❑ **PPO 1500** ❑ **FFS 1500**

†If you choose plans 200 or 250, you must select a dentist:

DENTIST'S NAME

ID #

❑ CHECK IF CURRENT DENTIST

PLEASE READ & SIGN THE BACK OF THIS FORM!

KP 0311 9/2009

Your LEGAL Acknowledgement *(Read, Sign & Date Below)*

By submitting this signed application, I agree and understand that the health plan chosen through the Kaiser Permanente Choice Solution program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the Kaiser Permanente Choice Solution Program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize *CHOICE* Administrators® and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the employer and considered eligible by my employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
- My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and **agree** to provide *CHOICE* Administrators® with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the third page of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.

Employee Signature Date:

Print Name

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse	Coverage begins on the first of month following date of marriage	■ Spouse must be legally married to eligible employee and the eligible employee must agree to notify *CHOICE* Administrators® immediately upon termination of the marriage
New Baby, Dependent Child, Grandchild†	Coverage will begin from the moment of birth through the end of the calendar month of birth, or the mother's hospitalization if she is a member, whichever is later. Premiums for continuation of coverage for the dependent will be charged beginning on the first of the month following the birth.	Child must be: ■ Born to, a step-child or legal ward of, grandchild† of, or adopted by the eligible employee or the spouse of the eligible employee or the domestic partner of the eligible employee ■ Dependent on the employee for at least 50% of his/her economic support ■ Unmarried or not involved in a domestic partnership ■ Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24 **Please note:** Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary. **Disabled Dependents:** Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually. Verification of eligibility will occur annually at the child's birthday **Dependents must meet all requirements listed in order to be eligible for enrollment**
Adopted Child, Stepchild, Non-Temporary Legal Ward	Coverage is effective on the date the member gains the right to control the dependent's healthcare, and premiums will be charged the first of the month following this date.	Child must be: ■ Adopted by, stepchild of, or non-temporary legal ward of the employee ■ Dependent on the employee for at least 50% of his/her economic support ■ Unmarried or not involved in a domestic partnership ■ Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24 **Please note:** Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary. **Disabled Dependents:** Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually. Verification of eligibility will occur annually at the child's birthday **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date Involuntary Loss of Other Coverage: Domestic partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month Mid-Year Addition: Mid-year additions of a domestic partner will require a State stamped copy of the Certificate of Registered domestic partnership within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnership	The employee and domestic partner must: ■ Share a common residence ■ Not be married under either a statutory or common law or part of another domestic partnership ■ Be 18 years of age or older ■ Share an intimate and committed relationship ■ Both be mentally competent ■ Not be related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify *CHOICE* Administrators® immediately upon termination of the domestic partnership **Employee/Domestic Partner must meet all requirements listed in order to be eligible for enrollment**
New Baby, Dependent Child, Grandchild†, Adopted Child, Stepchild, Non-Temporary Legal Ward of Domestic Partner	See Domestic Partner above	Child must be: ■ Born to, dependent child of, step-child of, grandchild† of, adopted by, or non-temporary legal ward of the domestic partner ■ Dependent on the employee for at least 50% of his/her economic support ■ Unmarried or not involved in a domestic partnership ■ Under age 19 (unless disabled, disability occurring prior to age 24) or a full-time student and under age 24 **Please note:** Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary. **Disabled Dependents:** Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually. Verification of eligibility will occur annually at the child's birthday **Dependents must meet all requirements listed in order to be eligible for enrollment**

† Grandchild may be covered if the parent is a dependent of the covered employee and the parent is also enrolled.

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