

# ENROLLMENT APPLICATION & CHANGE FORM



1 Type of Enrollment

Effective date        
 New Enrollment or  Change Enrollment

Add dependent  
 Delete dependent  
 Other: \_\_\_\_\_

Product Selection  
 HMO Select

For employer use only  
 Group #:     -

**COVERAGE LEVEL**  
 Individual  Parent/Child(ren)  Two Adults  Family

2 Tell Us About Yourself

Subscriber Name (last, first, middle) \_\_\_\_\_  
 Home Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number (Daytime) (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_\_\_  
 Your Employer's Name: J O H N S H O P K I N S U N I V E R S I T Y  
 Street Address: 3 4 0 0 N C h a r l e s S t r e e t  
 City B a l t i m o r e State M D Zip 2 1 2 1 8 - 2 6 9 5

3 A&B About Your Dependents & Selecting a Primary Care Physician (PCP)

Last, First, Initial	Sex	Social Security #	Date of Birth	Provider Code
	M F		Month Day Year	
S E L F				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

Have you or any of your dependents listed above ever been members of Kaiser Permanente before? Yes No If yes, indicate current name and name under which each was covered, if different: \_\_\_\_\_

4 Other Insurance Coverage

Are you or any member of your family covered by another group health insurance plan? Yes No If yes, indicate:  
 Name and Phone # of Plan \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Persons Covered \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Termination Date (if applicable) \_\_\_\_\_  
 Name and Phone # of Employer Who Provides Coverage \_\_\_\_\_

5 Please Sign Your Name

I hereby apply for membership in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. or change in membership status for myself and any eligible dependents and authorize my employer to make deductions, if any required, as my contribution for the premium.  
 I hereby assign Health Plan authorization to bill my/spouse's primary group insurance plan for all covered services provided or arranged by physicians with said Plan so long as I am a member of said Plan and such group plan is primary to Health Plan under Coordination of Benefits provisions. I understand that this coordination of benefits does not limit my rights to receive reimbursement for services I receive from non-Plan physicians.

The information provided above is true and correct to the best of my knowledge and meets the eligibility guidelines of my employer.  
 I understand that my coverage and my benefits may be affected by failure to provide complete and accurate information of a material nature.  
**If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing the application or card.**  
**Stop! Before you sign this application, make sure you have filled it out completely including selecting a primary care physician for you and each of your enrolled dependents.**

Signature of Applicant (Subscriber) \_\_\_\_\_ Date of Application \_\_\_\_\_



## GROUP ENROLLMENT APPLICATION & CHANGE FORM

Welcome to Kaiser Permanente! We look forward to you becoming a valued member of Kaiser Permanente. If you have any questions about enrolling in Kaiser Permanente, call Member Services at (301) 468-6000 or (800) 777-7902.

After you complete this form, please sign it and return it to your employer's payroll or benefits office. Do not send this application to Kaiser Permanente unless otherwise instructed.

If you are Medicare-eligible, there is a separate enrollment process. Call Member Services for information.

### **How to Complete This Application**

Please print all information.

#### **Section 1: Select your enrollment status and plan.**

Use this form to enroll or change (add or delete) your family members' membership status. To be a subscriber, you must live or work within our Service Area when you initially enroll. If you have any questions, see your employer's payroll or benefits office.

Enrollment and changes should be reported within 30 days of attaining eligibility or a change in status

Please select the plan option you are joining. If you are uncertain, see your employer's payroll or benefits office.

#### **Section 2: Please tell us about yourself.**

##### **Section 3A: Please tell us about your dependents.**

Make sure your family dependents meet your group's eligibility guidelines. If you have any questions, see your employer or benefits office.

##### **Section 3B: Select a primary care physician (PCP) for yourself and each dependent.**

To select a primary care physician please review Kaiser Permanente's provider directory of physicians and other health care professionals. Enter the provider code of the primary care physician you and each member of your family selects. If you need a directory, please call Member Services.

#### **Section 4: About other group insurance.**

Tell us if you, your spouse, or other family dependents are covered by other group health insurance plans.

Some families have health coverage under two separate health plans. For example, this may occur when both spouses are employed and have health care benefits from different carriers.

If you and/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 can eliminate most of your out-of-pocket expenses for services now only partially covered by those plans.

When you receive services authorized by Kaiser Permanente, we will bill your primary carrier for you and set up a benefit reserve account. Kaiser Permanente will keep track of any savings we receive from your primary carrier and credit it into a benefit reserve account for you. The money in the benefit reserve account is used to reimburse you for out-of-pocket expenses for medical services that are only partially covered by either one of your health plans. Incurred expenses and credits to the benefit reserve account must occur in the same calendar year.

If you qualify for Coordination of Benefits, your signature on this application gives Kaiser Permanente permission to coordinate benefits with your alternate carrier. For more information on Coordination of Benefits, please call Member Services.

#### **Section 5: Review and sign your applications.**

Keep a copy of this application as verification of enrollment or change until you receive your member ID card. Before you sign this application, please make certain you have read all coverage materials and have selected a primary care physician. Failure to complete all relevant parts of the application may delay or prevent enrollment and the issuance of a member ID card.

### **Receiving Care After Enrollment**

Your member ID card should arrive shortly after your effective date. However, if you do not receive a member ID card, you and your covered dependents can still receive services through Kaiser Permanente as of your effective date of coverage. Your effective date of coverage is provided by your employer. Call Member Services for more information.

**Here are important telephone numbers to keep handy until your member identification card arrives:**

*Member Services:*

Washington, DC Metropolitan area	(301) 468-6000
Outside Washington, D.C.	(800) 777-7902

*To schedule an appointment or to receive medical advice, call:*

Washington, DC Metropolitan Area:	(703) 359-7878
Baltimore Metropolitan Area:	(800) 777-7904

*For 24-hour emergency assistance, call: (800) 677-1112*