KAISER PERMANENTE®

Kaiser Permanente for Individuals and Families

ACCOUNT CHANGE FORM

Grandfathered
California

Instructions

There are different types of plan and account changes you can make with this form. Please fill out your information in Section A, look at the options listed below, and complete the section(s) for the plan or account change(s) you would like to make. In Section A, write the effective date you would like for your plan or account change (effective dates are not guaranteed).

A. Fill Out Your Information

Fill this out if you are the subscriber/new subscriber or person responsible for payment.

○ Check here if your address or phone numbers have changed.

First name	MI	Last name	Medical record number

Home address	City	State	ZIP
Billing address (○ Check if the same as the home address.)	**City**	**State**	**ZIP**

Phone	Social Security number	Requested future effective date (mm/01/yyyy) (must be the 1st of the month)
( ) -		

B. What Change(s) Do You Want To Make?

Please check the circles for the changes you wish to make, and below, 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 am ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ○ I am ending my coverage on a family plan and wish to continue on my own on an individual plan.
- ○ I wish to switch the subscriber and spouse/domestic partner roles on our current plan.
- ○ I wish to combine accounts. (Please pick your plan on page 2.)
- ○ I am ending my coverage but wish to keep my child(ren) on the plan.
- ○ I am ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ○ I wish to change plans. (Please select your plan on page 2.)
- ○ I wish to add medical coverage for a newborn or newly adopted child.
- ○ I wish to end medical coverage for a family member.
- ○ I wish to add optional dental coverage (for members 19 and older). (Please select your option on page 2.)
- ○ I wish to end optional dental coverage.

C. Which Family Members Are Affected by the Change?

(Please list below.)

Spouse/domestic partner ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 1 ○ Add medical coverage ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 2 ○ Add medical coverage ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

(continues on page 2)

C. Which Family Members Are Affected by the Change? *(continued from page 1)*

Dependent 3 ○ Add medical coverage ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 4 ○ Add medical coverage ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Dependent 5 ○ Add medical coverage ○ End medical coverage ○ Add optional dental coverage ○ End optional dental coverage

First name	Middle name	Last name	Medical record number (if any)

Sex ○ Male ○ Female	Social Security number	Date of birth (mm/dd/yyyy)

Option 1: Choose Your Health Plan

If your desired plan is listed below your current plan, you **may** change into that plan. If your desired plan is listed above your current plan, you may **not** change into that plan. Check the circle next to the plan you would like to change into. Each family member listed above will be moved into the plan you select. If you wish to enroll family members in different plans, please send back a separate form for each plan.

Once 30 days have passed from your new grandfathered plan's effective date, you will not be able to change back to your previous plan.

- ○ Copayment 25
- ○ Deductible 20/500
- ○ Copayment 40
- ○ Deductible 25/1000
- ○ Copayment 50
- ○ Deductible 30/1500
- ○ Deductible 40/2000
- ○ Deductible 0/1500 with HSA
- ○ Deductible 0/2700 with HSA
- ○ Deductible 30/2700 with HSA

Option 2: Choose Your Optional Dental Plan

You can enroll in or end dental coverage in the optional Dental Insurance Plan during open enrollment, annual member renewal, or a special enrollment period. Optional dental coverage is available for an additional monthly charge. Our optional dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers.

○ Add optional dental coverage. ○ End optional dental coverage.

Plan Change Agreement

Benefits vary among plans, so make sure you are comfortable with all the benefits of your selected plan. If you'd like to see a more detailed list of benefits, please call **1-800-464-4000** for a copy of the *Membership Agreement, Disclosure Form, and Evidence of Coverage*. This will help you be certain you don't accidentally forfeit a benefit you want.

If we accept your application, we will tell you the date that the new coverage begins. If you change your plan, once 30 days have passed from your new grandfathered plan's effective date, you will not be able to change back to your previous plan. Your current plan account must be paid up to the new plan effective date in order for you to change plans.

I understand the difference between my current benefits and the new grandfathered plan benefits and accept that change.

Subscriber or parent or legal guardian for a member under age 18 X	Date (mm/dd/yyyy)
Spouse/domestic partner X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)

Sign the Kaiser Foundation Health Plan Arbitration Agreement *(continued from page 2)*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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 *Membership Agreement, Disclosure Form, and Evidence of Coverage.*

Subscriber or parent or legal guardian for a member under age 18 X	Date (mm/dd/yyyy)
Spouse/domestic partner X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)
Dependent (age 18 or older) X	Date (mm/dd/yyyy)

Sign the Form

I understand that if I knowingly provide false, incomplete, or misleading information on this Account Change Form for the purpose of obtaining coverage, my coverage may be rescinded, meaning that my contract will be declared null and void as if it had never occurred.

For all account and plan changes, the subscriber and any new dependents 18 or older must sign.

Subscriber/new subscriber (parent or legal guardian for a member under 18) X	Date
Spouse/domestic partner (18 or older) X	Date
Dependent (18 or older) X	Date
Dependent (18 or older) X	Date
Dependent (18 or older) X	Date

Contact Information

Mail to: Kaiser Permanente
P.O. Box 23127
San Diego, CA 92193-9921

Or fax toll free to: Membership Administration
1-866-519-5139

Questions? Call 1-866-410-7536.