KAISER PERMANENTE®

3283187601

Individual and Family Plans

Account Change Form

Grandfathered
Maryland

Instructions

- There are different types of account changes you can make with this form. Please fill out your personal information in Section A and select the date you'd like your plan or account change to take effect (effective dates are not guaranteed). Then select what changes you'd like to make in Section B.

A. Fill out your information

Please select one: I'm the ☐ subscriber, ☐ spouse/domestic partner or dependent child 18 and older, or ☐ parent or legal guardian.
If you're making a change, please update the boxes below with your new information.

First name

Social Security number (if any) ___ - __ - ____

Last name

Date of birth (mm/dd/yyyy) __ / __ / ____

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Phone ___ - ___ - ____

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

City

State

ZIP code

Billing address ☐ Check if the same as the home address.

City

State

ZIP code

Requested future effective date (date must be the 1st of the month) __ / 01 / ____

B. What change(s) do you want to make?

Subscribers (or the parent or legal guardian for subscribers under 18) can make all the changes below for any family members. Dependents can make some changes only for themselves – see those changes marked with an asterisk (*) below.

- ☐ I'm ending my coverage and wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.*
- ☐ I wish to change the subscriber.
- ☐ I wish to change the parent/legal guardian on a child-only account.
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)*
- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ I wish to add medical coverage for a newborn or newly adopted child.
- ☐ I wish to end medical coverage for myself* or a family member.

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

Spouse/domestic partner

☐ End medical coverage

First name

Last name

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Choose one: ☐ Spouse ☐ Domestic partner

Social Security number (if any) - -

Date of birth (mm/dd/yyyy) / /

Phone - -

Dependent 1

☐ Add medical coverage ☐ End medical coverage

First name

Last name

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Social Security number (if any) - -

Date of birth (mm/dd/yyyy) / /

Phone - -

Dependent 2

☐ Add medical coverage ☐ End medical coverage

First name

Last name

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Social Security number (if any) - -

Date of birth (mm/dd/yyyy) / /

Phone - -

Dependent 3

☐ Add medical coverage ☐ End medical coverage

First name

Last name

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Social Security number (if any) - -

Date of birth (mm/dd/yyyy) / /

Phone - -

Dependent 4

☐ Add medical coverage ☐ End medical coverage

First name

Last name

MI

Medical record number (if any)

Gender: ☐ Male ☐ Female

Social Security number (if any) - -

Date of birth (mm/dd/yyyy) / /

Phone - -

D. Sign the form

- I understand that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), will rely on the information provided in this form. I understand if I commit fraud or intentional misrepresentation of material fact, then Health Plan may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30-days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.
- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 301-468-6000 or 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

Note: The subscriber and all dependents 18 and older making a change must sign the form. If there are more than 4 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

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

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

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

Spouse/domestic partner

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

Dependent (18 and older)

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

Dependent (18 and older)

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

Dependent (18 and older)

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

Dependent (18 and older)

Contact information

Mail to: Employer Services Dept./KPIF 5W Kaiser Permanente for Individuals and Families 2101 E. Jefferson St. Rockville, MD 20852-9995	**Or fax toll-free to:** Membership Administration **1-855-414-2796**	**Questions? Call** **301-468-6000** or **1-800-777-7902**

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (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 **1-800-777-7902** (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 or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) **ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (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. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (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。**1-800-777-7902**（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. **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-800-777-7902** (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 **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

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