



## Instructions

There are different types of plan changes and 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.

<p>First name</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Social Security number (if any)</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Last name</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Date of birth (mm/dd/yyyy)</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>MI <input style="width: 20px; height: 20px;" type="text"/></p>	<p>Medical record number (if any)</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>Phone</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Home address (no P.O. boxes, please)</p> <input style="width: 100%; height: 20px;" type="text"/>	
<p>City</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>State <input style="width: 20px; height: 20px;" type="text"/> ZIP code <input style="width: 20px; height: 20px;" type="text"/></p>
<p>Billing address <input type="checkbox"/> Check if the same as the home address.</p> <input style="width: 100%; height: 20px;" type="text"/>	
<p>City</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>State <input style="width: 20px; height: 20px;" type="text"/> ZIP code <input style="width: 20px; height: 20px;" type="text"/></p>
<p>Requested future effective date (date must be the 1st of the month)</p> <input style="width: 100%; height: 20px;" type="text"/>	

### 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.

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

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

If you have more than 4 dependents with a change, attach a copy of this page and complete the information for those dependents.

#### Spouse/domestic partner

End medical coverage

First name

Social Security number (if any)

 -  - 

Last name

Date of birth (mm/dd/yyyy)

 /  / 

MI

Medical record number (if any)

Gender:

Male

Female

Choose one:

Spouse

Domestic partner

Phone

 -  - 

#### Dependent 1

Add medical coverage

End medical coverage

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

 -  - 

#### Dependent 2

Add medical coverage

End medical coverage

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

 -  - 

#### Dependent 3

Add medical coverage

End medical coverage

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

 -  - 

#### Dependent 4

Add medical coverage

End medical coverage

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

 -  -

## 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 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.

<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
Subscriber/new subscriber (parent or legal guardian for subscribers under 18)	
X <input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
Spouse/domestic partner (18 and older)	
X <input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent (18 and older)	
X <input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent (18 and older)	
X <input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent (18 and older)	
X <input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
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**  
**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 ሊያገዝዎት ተዘጋጅተዋል። 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**) .

**Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo:** ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò béin m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

**বাংলা (Bengali) লক্ষ্য করুন:** 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) NRUBAMA:** O bụrụ na i na asụ Igbo, orụ enyemaka asụsụ, n'efu, dijiri gi. 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'déé', t'áá jiik'eh, éi ná hóló, koji' 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:** ถ้าวัดคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: 711).

**اردو (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).

This page is intentionally left blank.

This page is intentionally left blank.

