KAISER PERMANENTE®

Charitable Health Coverage
Account Change Form

Questions for Charitable Health Coverage Members

For section C, please answer the following questions for each dependent who will be covered by the health plan and is applying for a Charitable Health Program subsidy in California, Georgia, Hawaii, Maryland, the Northwest, or Virginia. If the applicant is under the age of 18, his or her parent or legal guardian should complete this section.

Is the primary dependent…

Offered health coverage through an employer?* ☐ Yes ☐ No

A U.S. citizen?*
If you answered yes, skip the following two questions. ☐ Yes ☐ No

A Lawful Permanent Resident[1]? ☐ Yes ☐ No

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

*Indicates a required field

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Georgia

Instructions

- You may use this form to make plan changes or account changes to an existing Kaiser Permanente for Individuals and Families (KPIF) account. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- 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. Then select what changes you'd like to make in Section B, and continue on to fill out any other sections related to those changes.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. To avoid paying for 2 plans or having a gap in coverage, please cancel any other coverage they have as of the day before their new coverage starts.
- Note: If you're entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to change KPIF plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF plan as a new dependent.

A. Fill out your information

If you're making a change, please update the boxes below with your new information.

First name | MI | Date of birth (mm/dd/yyyy) / /

Last name

Medical record number (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

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

City

State | ZIP code | County | Phone (mobile phone if available) - -

Mailing address ☐ Check if same as the home address.

City

State | ZIP code

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

Please check the boxes below for the changes you wish to make and list each family member affected. We won't make any changes for any family members you don't list.

You can make the following changes during open enrollment or a special enrollment period. To make a change other than listed below, you can call Member Services at **1-888-865-5813** (TTY **711**).

- ☐ I wish to change plans.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to change my child-only account to a family account with myself as the subscriber.

(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

Combine Accounts

Accounts can be combined during open enrollment or a special enrollment period.

☐ I wish to add (a) family member(s) already on a Kaiser Permanente plan to my account. Doing this will end their existing plan. (Please indicate which family member(s) will move to your account in Section C.)

Account ending

First name | MI

Last name

Subscriber medical record number for account ending

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

Subscriber or parent/legal guardian for account ending

You can make the following changes any time during the year. *(Note: For these changes, you can skip Sections D and E.)*

- ☐ I wish to end medical coverage (and dental coverage, if applicable) for a family member.
- ☐ I'm ending my coverage and I wish to keep my child(ren) on a child-only account.
- ☐ I'm ending my and my spouse's/domestic partner's coverage and I wish to keep my child(ren) on a child-only account.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)

Requested effective date (not guaranteed) __/__/____ (mm/dd/yyyy)

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

Spouse/Domestic partner

☐ Add medical coverage
☐ End medical coverage

☐ Name Change

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

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

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) ___-___-____

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents.

Dependent 1

☐ Add medical coverage
☐ End medical coverage

☐ Name Change

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependent 2

☐ Add medical coverage
☐ End medical coverage

☐ Name Change

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependent 3

☐ Add medical coverage
☐ End medical coverage

☐ Name Change

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

D. Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Section E)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care

  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Child support order or other court order to cover a dependent

  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Determination by the health benefit exchange of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution to COBRA premium

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.

E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Each family member you listed in Section C will be moved to the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan.

- ☐ KP GA Signature Bronze Virtual Complete 5500/1500 RxDed
  KP GA Signature Bronze Virtual Complete 5500/1500 RxDed†
- ☐ KP GA Bronze 6500/40%/HSA
  KP GA Signature Bronze 6500/40%/HSA†
- ☐ KP GA Standard Bronze 7500/50
  KP GA Signature Standard Bronze 7500/50†
- ☐ KP GA Silver 3400 Ded/500 Rx Ded
  KP GA Signature Silver 3400 Ded/500 Rx Ded†
- ☐ KP GA Silver 4500/35
  KP GA Signature Silver 4500/35†
- ☐ KP GA Standard Silver 5900/40
  KP GA Signature Standard Silver 5900/40†
- ☐ KP GA Silver Virtual Complete 5000
  KP GA Signature Silver Virtual Complete 5000†
- ☐ KP GA Silver Virtual Complete 5500
  KP GA Signature Silver Virtual Complete 5500†
- ☐ KP GA Gold 500 Ded/500 Rx Ded
  KP GA Signature Gold 500 Ded/500 Rx Ded†
- ☐ KP GA Gold 1500 Ded/500 Rx Ded
  KP GA Signature Gold 1500 Ded/500 Rx Ded†
- ☐ KP GA Gold 2000 Ded/500 Rx Ded
  KP GA Signature Gold 2000 Ded/500 Rx Ded†
- ☐ KP GA Standard Gold 1500/30
  KP GA Signature Standard Gold 1500/30†

For applicants under 30 or with hardship exemptions

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

- ☐ KP GA Catastrophic 9450
  KP GA Signature Catastrophic 9450†

†If you live in Clayton, Cobb, DeKalb, Fulton, Gwinnett, or Henry counties, your plan will be in the KP Signature HMO network. Please see the KPIF Enrollment Guide for important information on plans with the KP Signature HMO network.

F. Sign the form

- I understand that Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA), will rely on the information provided in this form, and that if any information is found to be fraudulent or intentionally misrepresented, KFHPGA may choose to terminate my coverage back to the coverage effective date.
- I verify that no one listed on this form who is changing plans or being added as a dependent is entitled to Medicare Part A or enrolled in Medicare Part B.
- If I worked with a broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $28, per member per month, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- By providing my email address and mobile phone number, I am agreeing to receive email and text communications from Kaiser Permanente.

Note: The subscriber making a change must sign the form.

X _____ Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

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

Contact information

Mail to: Kaiser Permanente P.O. Box 23127 San Diego, CA 92193	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-888-865-5813 (**TTY **711)**

All plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc.,
Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, 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 **1-888-865-5813** (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 at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

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.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (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 **1-888-865-5813**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-888-865-5813** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

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。**1-888-865-5813**（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. **1-888-865-5813** (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 **1-888-865-5813** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (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 **1-888-865-5813** (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 **1-888-865-5813** (TTY: **711**).

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