KAISER PERMANENTE®

Community Health Access Program
Account Change Form

When to use this form

Use this form to make changes to your Kaiser Permanente Community Health Access Program account, which provides help in paying your health plan premiums and out-of-pocket costs. This form is not for applying for coverage in Kaiser Permanente's MD Gold 0/20 plan.

How to complete and submit this form

Please complete all sections of this form that apply to your change, using black or blue ink. See the table below for sections that need to be completed. Be sure to sign and date the form.

Not all changes to your account need to be made using this form. Some changes can be made by phone. To make changes by phone, please call Member Services at **1-800-777-7902,** Monday through Friday, 7:30 a.m. to 5:30 p.m. Eastern time (ET). TTY users, call **711.**

Type of change	Complete the following sections	Submit the form
Update my contact information (address, telephone number)	A, B, G Or call us to request the change	Mail or fax the completed form
Change a name	A, C, G	Mail or fax the completed form and any supporting documentation (such as a driver's license, marriage certificate, or divorce decree)
Remove a dependent from my account	A, D, G Or call us to request the change	Mail or fax the completed form
Cancel membership for everyone on account	A, E, G Or call us to request the change	Mail or fax the completed form
Add a dependent to my account	A, F, G, plus Special Enrollment Period guide and form (if making request outside of open enrollment, call us to obtain the guide/form)	Mail or fax the completed form, the Special Enrollment Period form, and any required supporting documentation

Contact information		
Mail to: California Service Center Attn: CHC P.O. Box 939095 San Diego, CA 92193-9095	**Or fax toll free to:** **1-858-614-3344**	**Questions?** We're here to help. Call **1-800-777-7902,** Monday through Friday, 7:30 a.m. to 5:30 p.m. Eastern time (ET). TTY users, call **711.**

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Maryland

A. Fill out your information

Please select one: I'm the ☐ primary member (must be over 18) ☐ parent/guardian (if primary member is under 18)

First name MI

Last name

Medical record number (if any) Date of birth (mm/dd/yyyy) / / Gender: ☐ Male ☐ Female

B. Update contact information

Fill out any information that's changed.

Mailing address

City State ZIP code

Home address, if different from mailing address (no P.O. boxes, please)

City State ZIP code

Email Phone - -

Written language preference Spoken language preference

C. Change a name

Whose name is changing? ☐ Child ☐ Spouse/domestic partner ☐ Primary member

Old name

First name MI

Last name

New name

First name MI

Last name

D. Remove a dependent from my account

If you're removing more than 2 dependents, make a copy of this page before filling it out and attach it with the form.

Dependent 1

First name | MI

Last name

Medical record number | Date of birth (mm/dd/yyyy) / /

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

Dependent 2

First name | MI

Last name

Medical record number | Date of birth (mm/dd/yyyy) / /

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

E. Cancel membership for everyone on account

☐ Please cancel membership in the Kaiser Permanente Community Health Access Program for everyone on this account. I understand that this will cancel enrollment in the Kaiser Permanente MD Gold 0/20 plan for everyone on this account.

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

F. Add a dependent

The Community Health Access Program includes financial help from Kaiser Permanente. To qualify for this help, any dependent you add must meet these requirements:

- Live in the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., service area, excluding the District of Columbia.
- Live in a household with incomes up to 300% of the federal poverty level (for example, $36,420 for an individual or $75,300 for a family of 4 per 2018 guidelines).
- Do not have access to any other public or private health coverage including, but not limited to, Medicaid, Medicare, a job-based health plan, or coverage through the Maryland Health Connection.

Eligibility rules are subject to change. Visit **kp.org/chc** for the latest requirements.

If you want to add a dependent outside of the open enrollment period:

- You must have had a qualifying life event (triggering event). For a list of qualifying life events, see the Special Enrollment Period guide and form. Call **1-800-777-7902** to get a form.
- **You must complete and send in the Special Enrollment Period form along with proof of your event.**

F. Add a dependent *(continued)*

- Please complete the information below for each dependent you want to add to your plan.
- If you want to add more than 2 dependents, make a copy of the page below before filling it out and attach it to the form.

For more information, please call Member Services at **1-800-777-7902,** Monday through Friday, 7:30 a.m. to 5:30 p.m. Eastern time (ET). TTY users, call **711.**

Dependent 1

First name ____________________ MI ____

Last name ____________________

Medical record number (if any) ____________________

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

Gender: ☐ Male ☐ Female

Social Security number (optional) ___-__-____

Relationship to primary member: ☐ Child ☐ Spouse/domestic partner ☐ Other ____________________

Is Dependent 1 ...

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident? If yes, how many years has the primary applicant been a legal permanent resident? ________	☐ Yes ☐ No
Eligible for health coverage through public programs such as Medicaid or Medicare?	☐ Yes ☐ No
Eligible for financial assistance through Maryland Health Connection?	☐ Yes ☐ No
Currently covered through or able to be covered through a job-based health plan or another health plan?	☐ Yes ☐ No

What month do you want Dependent 1's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy) ___ / ____

(continues)

F. Add a dependent *(continued)*

Dependent 2

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical record number (if any) ☐☐☐☐☐☐☐☐☐☐☐☐

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

Gender: ☐ Male ☐ Female

Social Security number (optional) ☐☐☐ - ☐☐ - ☐☐☐☐

Relationship to primary member: ☐ Child ☐ Spouse/domestic partner ☐ Other ______

Is Dependent 2 ...

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident? If yes, how many years has the primary applicant been a legal permanent resident? ______	☐ Yes ☐ No
Eligible for health coverage through public programs such as Medicaid or Medicare?	☐ Yes ☐ No
Eligible for financial assistance through Maryland Health Connection?	☐ Yes ☐ No
Currently covered through or able to be covered through a job-based health plan or another health plan?	☐ Yes ☐ No

What month do you want Dependent 2's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy) ☐☐ / ☐☐☐☐

G. Signature

By signing this form, you certify the information on this form is correct and accurate. If you provide any incorrect or incomplete information on this form or in further correspondence concerning this form, any Kaiser Permanente subsidy to cover costs related to health coverage may be terminated. Membership approval for Kaiser Permanente's Community Health Access Program is not guaranteed as it is based on eligibility and availability.

X ____________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Signature (primary member or financially responsible party, parent, or legal guardian for applicants under 18)

X ____________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Signature of primary member (if 18 or older)

X ____________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Signature of current parent or legal guardian (if primary member is under 18)

X ____________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Signature of new adult dependent (18 or older)

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Permanente Insurance Company (KPIC), Ordway Building, One Kaiser Plaza, Oakland, CA 94612

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 ኣማርኛ 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. Đá **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'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, 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**).