

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 most out-of-pocket costs. This form is not for applying for coverage in Kaiser Permanente's MD Gold Value 0/20/Vision plan.

How to complete and submit this form

Please complete all sections 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 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 (TTY 711)**, Monday through Friday, 7:30 a.m. to 9 p.m. Eastern time (closed major holidays).

Type of change	Complete the following sections	Submit the form
Update my contact information	A, B, H Or call to request the change	Email, fax, or mail the completed form
Change a name	A, C, H	Email, fax, or mail the completed form and any supporting documentation (such as a driver's license, marriage certificate, or divorce decree)
Remove a dependent	A, D, H Or call to request the change	Email, fax, or mail the completed form
Cancel membership for everyone on the account	A, E, H Or call to request the change	Email, fax, or mail the completed form
Add a dependent	A, F, H	Email, fax, or mail the completed form and any required supporting documentation
Change the parent/legal guardian of a covered dependent	A, G, H	Email, fax, or mail the completed form and any supporting documentation of guardianship (such as a court order)

Contact information

Email to: CHC-Applications@kp.org Fax toll-free to: 1-855-355-5334	Mail to: California Service Center Attn: CHC P.O. Box 939095 San Diego, CA 92193-9095	Questions? We're here to help. Call 1-800-777-7902 (TTY 711) , Monday through Friday, 7:30 a.m. to 9 p.m. Eastern time (closed major holidays)
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A. Fill out your informationPlease select one: I'm the ☐ primary member (must be 18 or older) ☐ 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

Written language preference

Spoken language preference

B. Update contact information

Fill out any information that's changed.

Mailing address (P. O. boxes acceptable)

City

State

ZIP code

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

City

State

ZIP code

Email

Home phone

 - -

Mobile phone

 - -

C. Change a name

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

Old name

First name

[illegible]

Last name

[illegible]

New name

First name

[illegible]

Last name

[illegible]

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

[illegible]

Last name

[illegible]

Medical record number

[illegible]

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

[illegible]

Last name

[illegible]

Medical record number

[illegible]

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 the 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 Value 0/20/Vision 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 Kaiser Permanente Community Health Access Program provides a subsidy to help pay your monthly premiums and most out-of-pocket medical costs under your current Kaiser Permanente plan.

Your dependent(s) may qualify for the Kaiser Permanente Community Health Access Program if they do not currently have health coverage and:

- 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 an income up to 300% of the federal poverty level
- Can't be eligible for other public or private health coverage such as, but not limited to, Medicaid, Medicare, a job-based health plan, or financial help through the Maryland Health Connection

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

If you're adding a dependent outside of the open enrollment period, you must have had a qualifying life event. For a complete list of qualifying life events, please visit kp.org/chcspecialenrollment or call **1-800-777-7902 (TTY 711)** for more information.

Choose the life event that made your dependent eligible for a special enrollment period:

- | | |
|---|--|
| <input type="checkbox"/> Loss of minimum essential health coverage (write the last full day you had coverage)* | <input type="checkbox"/> Death of the subscriber or a dependent |
| <input type="checkbox"/> Gaining or becoming a dependent through marriage / domestic partnership | <input type="checkbox"/> Permanent relocation with access to new plans |
| <input type="checkbox"/> 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:
<input type="checkbox"/> The date of birth, adoption, or placement for adoption or foster care
<input type="checkbox"/> The first day of the month after gaining the dependent | <input type="checkbox"/> 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:
<input type="checkbox"/> The date of the child support order or other court order to cover a dependent
<input type="checkbox"/> The first day of the month after the court order date |
| <input type="checkbox"/> Losing a dependent through divorce, dissolution of domestic partnership, or legal separation | |

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 your prior membership records to verify loss of minimum essential coverage.

Proof of your qualifying life event is required.

- For loss of health care coverage, attach proof, such as a letter from your employer, letter from your insurer, or Medicaid, Medi-Cal, Medicare, or other government programs stating when your dependent's minimum essential coverage ended or will end.
- For examples of required proof of other qualifying life events, please visit kp.org/chcspecialenrollment or call **1-800-777-7902 (TTY 711)**.

(continues)

F. Add a dependent (continued)

Please complete the information below. If you're adding more than 2 dependents, attach another form and complete just the information for those dependents.

Dependent 1

First name	MI	Last name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security number (optional)	Medical record number	Date of birth (mm/dd/yyyy)
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Gender:	Relationship to primary member:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse/Domestic partner <input type="checkbox"/> Child/Dependent	

Is Dependent 1 ...

A U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A legal permanent resident? If yes, how many years has the dependent been a legal permanent resident? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your job offer health coverage for this dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="text"/> / <input type="text"/> (mm/yyyy)	

Dependent 2

First name	MI	Last name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security number (optional)	Medical record number	Date of birth (mm/dd/yyyy)
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Gender:	Relationship to primary member:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse/Domestic partner <input type="checkbox"/> Child/Dependent	

Is Dependent 2 ...

A U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A legal permanent resident? If yes, how many years has the dependent been a legal permanent resident? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your job offer health coverage for this dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="text"/> / <input type="text"/> (mm/yyyy)	

G. Change parent/legal guardian of a covered dependent

The new parent or legal guardian must be 18 or older and financially responsible for the covered dependent. **You must include documentation of guardianship with your form.**

Current parent or legal guardian

First name

[illegible]

--	--

Last name

[illegible]

X _____

Signature of current parent or legal guardian

New parent or legal guardian

First name

[illegible]

--	--

Last name

[illegible]

X _____

Signature of new parent or legal guardian

Information about the new parent or legal guardian:

Date of birth (mm/dd/yyyy)

$$\boxed{}\boxed{} / \boxed{}\boxed{} / \boxed{}\boxed{}\boxed{}\boxed{}$$

Social Security number (optional)

Phone

Gender: ☐ Male ☐ Female

Relationship to primary member: ☐ Parent ☐ Legal guardian

Marital status: ☐ Single ☐ Married ☐ Domestic partner ☐ Divorced ☐ Separated ☐ Widowed

H. Signature

By signing this form, you certify the information on this form is correct and accurate. If you provide any incorrect or incomplete information 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	<div></div>	Date (mm/dd/yyyy) <div></div> / <div></div> / <div></div> <div></div>
	Required signature (primary member or parent/legal guardian for applicants under 18)	
X	<div></div>	Date (mm/dd/yyyy) <div></div> / <div></div> / <div></div> <div></div>
	Required signature of primary member (18 and older)	
X	<div></div>	Date (mm/dd/yyyy) <div></div> / <div></div> / <div></div> <div></div>
	Required signature of current parent/legal guardian (if primary member is under 18)	
X	<div></div>	Date (mm/dd/yyyy) <div></div> / <div></div> / <div></div> <div></div>
	Required signature of new adult dependent (18 and older)	

In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson St., Rockville, MD 20852.

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 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**)፡

Bàsɔ̀̀ Wùdù (Bassa) Dè dɛ nàà kɛ dyédé gbo: ɔ jũ ké m̀ Bàsɔ̀̀-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dɔ̀ po-poò béin m̀ gbo kpáa. Dá **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 નિઃશુલ્ક 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 buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. Kpoo **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, éí ná hóló, kóji' 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).

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).