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

**How to complete and submit this form**

Please complete all sections that apply to your change, type or print 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 9:00 p.m. Eastern time (closed major holidays)

| Type of change | Complete the following sections | Submit the form |
|---|---|---|
| Update my contact information | A, B, H<br>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<br>Or call to request the change | Email, fax, or mail the completed form |
| Cancel membership for everyone on the account | A, E, H<br>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: | Mail to: | Questions? |
|---|---|---|
| **CHC-Applications@kp.org**<br>**Fax toll-free to:**<br>**1-855-355-5334** | California Service Center<br>Attn: CHC<br>P.O. Box 939095<br>San Diego, CA 92193-9095 | We're here to help. Call<br>**1-800-777-7902** (TTY **711**)<br>Monday through Friday, 7:30 a.m. to 9:00 p.m. Eastern time (closed major holidays). |

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Community Health Access Program

# Account Change Form

## Virginia

## A. Fill out your information

Please 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 (Include Apt. Number. P.O. boxes acceptable)

City | State | ZIP code

Home address, if different from mailing address (Include Apt. Number. No P.O. boxes, please)

City | State | ZIP code

Email (optional) *I understand I may be contacted via email.*

Home phone - - | Mobile phone - -

## C. Change a name

Whose name is changing? ☐ Child ☐ Spouse ☐ 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 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 VA Gold 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, FAMIS, Medicare, a job-based health plan, or financial help through the health benefit exchange.

These rules are subject to change. Visit **kp.org/mas-chap** for the latest requirements.

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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:**

- ☐ Loss of minimum essential health coverage (write the last full day your dependent had coverage)*
- ☐ Gaining or becoming a dependent through marriage
- ☐ 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
- ☐ Permanent relocation with access to new plans
- ☐ 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
- ☐ Determination by the health benefit exchange of exceptional circumstances

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.

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**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

Social Security number (optional) - - | Medical record number | Date of birth (mm/dd/yyyy) / /

Gender:
☐ Male ☐ Female

Relationship to primary member:
☐ Spouse ☐ Child/Dependent

If Dependent 1 is 21 and older: Has Dependent 1 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

**Is Dependent 1 ...**

| | |
|---|---|
| A U.S. citizen? | ☐ Yes ☐ No |
| A legal permanent resident?<br>If yes, how many years has the dependent been a legal permanent resident? _____ | ☐ Yes ☐ No |
| Does your job offer health coverage for this dependent? | ☐ 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)

### Dependent 2

First name | MI | Last name

Social Security number (optional) - - | Medical record number | Date of birth (mm/dd/yyyy) / /

Gender:
☐ Male ☐ Female

Relationship to primary member:
☐ Spouse ☐ Child/Dependent

If Dependent 2 is 21 and older: Has Dependent 2 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

**Is Dependent 2 ...**

| | |
|---|---|
| A U.S. citizen? | ☐ Yes ☐ No |
| A legal permanent resident?<br>If yes, how many years has the dependent been a legal permanent resident? _____ | ☐ Yes ☐ No |
| Does your job offer health coverage for this dependent? | ☐ 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. 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 MI

Last name

X

Signature of current parent or legal guardian

Date (mm/dd/yyyy) / /

### New parent or legal guardian

First name MI

Last name

X

Signature of new parent or legal guardian

Date (mm/dd/yyyy) / /

### Information about the **new** parent or legal guardian:

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

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 _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

**Required signature** (primary member or parent/legal guardian for applicants under 18)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

**Required signature** of primary member (18 and older)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

**Required signature** of current parent/legal guardian (if primary member is under 18)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

**Required signature** of new adult dependent (18 and older)

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.

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## 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**).

**Ɓǎsɔ́ɔ̀ 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) સૂચના:** 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**).