

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

Please check the boxes below for the changes you wish to make, and on the next page, 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.

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

- | | |
|--|--|
| <input type="checkbox"/> I wish to change plans. | <input type="checkbox"/> I wish to add adult dental coverage (for members 19 and older). |
| <input type="checkbox"/> I wish to add medical coverage for a family member. | <input type="checkbox"/> I wish to add pediatric dental coverage (for members 18 and younger). |
| <input type="checkbox"/> I wish to change my child only account to a family account with myself as the subscriber. | |

Combine Accounts

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

- I wish to add a family member(s) that is 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 health 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.)

- | | |
|---|--|
| <input type="checkbox"/> I wish to end medical coverage for myself or for a family member. | <input type="checkbox"/> Someone on my account stopped using tobacco.
(Please indicate which family member in Section C.) |
| <input type="checkbox"/> I'm ending my coverage and I wish to keep my child(ren) on a child only account. | <input type="checkbox"/> I wish to end adult dental coverage. |
| <input type="checkbox"/> 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. | <input type="checkbox"/> I wish to end pediatric dental coverage. |
| <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.) | |

Requested effective date (not guaranteed)

 / / (mm/dd/yyyy)

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

Spouse/Domestic partner

- | | | |
|---|--|--|
| <input type="checkbox"/> Add medical coverage | <input type="checkbox"/> Add adult dental coverage | <input type="checkbox"/> Add pediatric dental coverage |
| <input type="checkbox"/> End medical coverage | <input type="checkbox"/> End adult dental coverage | <input type="checkbox"/> End pediatric dental coverage |

- Name change

First name

MI

Choose one:

- Spouse Domestic partner

Last name

Date of birth (mm/dd/yyyy)

 / /

Health 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/speciaленrollment or call **1-800-255-5169** for more about qualifying life events.

- | | |
|---|--|
| <input type="checkbox"/> Loss of minimum essential health coverage (write the last full day you had coverage)* | <input type="checkbox"/> Permanent relocation with access to new plans |
| <input type="checkbox"/> Gaining or becoming a dependent through marriage or domestic partnership | <input type="checkbox"/> Determination by the Oregon Health Insurance Marketplace of exceptional circumstances |
| <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 the birth or placement of the child with you | <input type="checkbox"/> Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) |
| <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"/> Domestic violence or spousal abandonment occurring within the household
<input type="checkbox"/> 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 KFHPNW 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.

- | | |
|---|--|
| <input type="checkbox"/> KP OR Standard Bronze Plan | <input type="checkbox"/> KP OR Silver 3500/40 X |
| <input type="checkbox"/> KP OR Bronze 8900/75 | <input type="checkbox"/> KP OR Silver 3000/35% HSA |
| <input type="checkbox"/> KP OR Bronze 6900/0% HSA | <input type="checkbox"/> KP OR Silver 750/30 X |
| <input type="checkbox"/> KP OR Bronze 5500/50 | <input type="checkbox"/> KP OR Standard Gold Plan |
| <input type="checkbox"/> KP OR Silver 4500/50 | <input type="checkbox"/> KP OR Gold 2000/20 |
| <input type="checkbox"/> KP OR Silver 4000/40 X | <input type="checkbox"/> KP OR Gold 0/20 |

F. Choose your dental plan

If you enroll in an Individuals and Families health plan, then by law you must also enroll in a separate pediatric dental plan with us or with another company, even if you are over 18. (Our family dental plans include the required pediatric dental benefits.)

- Everyone on this form must apply for the same dental plan.
- If anyone in your family wants to apply for a different dental plan, please submit a separate account change form.

Family Dental Plans

I'd like dental coverage for:

- Adults only (ages 19 and older)
 Adults and children
 Children only (ages 18 and younger)

Please select your dental plan.

- KP OR Dental 100
 KP OR Dental 80H
 KP OR Dental 80L

G. Sign the form

- I understand that it may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and the cancellation of my policy.
- 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 am not purchasing a pediatric dental plan, I attest that I and other dependents on the application have obtained and will maintain a pediatric dental plan certified by the Oregon Health Insurance Marketplace.
- If I worked with a producer, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is \$18 for medical plans and \$2.50 for dental plans, 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 understand I may 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
1-800-813-2000 (TTY 711)

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. 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 Member Services at **1-800-813-2000** (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, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239**.

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, Phone: 1-800-368-1019, TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማህታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (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**1-800-813-2000** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-813-2000** (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。**1-800-813-2000** (TTY: **711**) まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊານ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-813-2000 (TTY: 711).

Afaan Oromoo (Oromo) XIYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).

