[redacted]

Employer or Union Name:

Group #:

LAST Name:

FIRST Name:

Middle Initial:

Gender:
☐ Male ☐ Female

Home Phone Number:

Mobile Phone Number:

Birth Date: (mm/dd/yyyy)

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

Permanent Residence Street Address (P.O. Box is not allowed):

City:

County:

State:

ZIP Code:

[redacted] (only if different from your Permanent Residence Address)

Street Address:

City:

State:

ZIP Code:

[redacted]:

Last Name | First Name

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Last Name _____ First Name _____

6. Requested effective date (subject to CMS approval): _____

A

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Black or African American

Asian:

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian

Native Hawaiian and Pacific Islander:

☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander

☐ White
☐

☐ Spanish ☐ Chinese ☐ Braille ☐ Large Print ☐ Audio CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name:

_____

Employer Group/Union/Trust Fund ID #: _____

Subgroup: _____

Requested effective date (subject to CMS approval): _____

Last Name | First Name

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

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If you are the authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this enrollment request on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above and provide your information below:

: