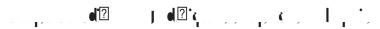
	A?	?	. , . 1 ,	•
Employer or Union Name:			Group #:	
LAST Name:				
FIRST Name:		Middl		Gender: Male Female
Home Phone Number:	Mobile Phone Number:		Birth Date:	(mm/dd/yyyy)
Are you a current or former member of any Kais health plan? Yes No If yes: Cu	urrent Former	Kaiser Permanent	te Medical/He	ealth Record Number:
Permanent Residence Street Address (P.O. Box is	s not allowed):			
City:				
County:			State:	ZIP Code:
(only if different from your Pe Street Address:	rmanent Residence Address)			
City:			State:	ZIP Code:
(I _ : ATE :				

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.

Senior Advantage - Group		Page 3 of 5			
Last Name First Name					
6. Requested effective date (subject to CM					
A,,,, ., , , , (
Are you Hispanic, Latino/a, or Spanish orig No, not of Hispanic, Latino/a, or Spanis Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanis	Sh origin Yes, Mexican, Mexican American, Chicano/a Yes, Cuban				
[
What's your race? Select all that apply. American Indian or Alaska Native Asian: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian	 □ Black or African American Native Hawaiian and Pacific Islander: □ Guamanian or Chamorro □ Native Hawaiian □ Samoan □ Other Pacific Islander □ White □ White 				
Spanish	Large Print Audio CD	Iv /v			
	0-443-0815 if you need information in an accessible format or language a week, 8 a.m. to 8 p.m. TTY users should call 711.	other than what			
	overage through more than one employer or union/trust fund, you mu hich to receive your Senior Advantage coverage. Complete the informa				
Employer Group/Union/Trust Fund Name:					
Employer Group/Union/Trust Fund ID #:	Subgroup: Requested effective date (subject to	CMS approval):			

Senior Advantage - Group	Page 4 of 5	
Last Name	First Name	

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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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d? . ',	
,	e authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this equest on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above

and provide your information below: