Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

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2017 Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign the back of this form.

Section 1: Retiree information

Medical effective date (mm/dd/yyyy)				
Social Security number	Last name (as appears on Medicare card)	First name	Middle initial	Sex ☐ M ☐ F
Permanent residential address (required)	Apt./unit number	City	State	ZIP Code + 4
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code + 4
County of residence	Date of birth (mm/dd/yyyy)	☐ Married (mm/dd/yyyy)	Home phone number (including area code)	
Retiree Medicare claim number	**Entitled to Part A (hospital)** ☐ Yes ☐ No If yes, effective date _____			
	Entitled to Part B (medical) ☐ Yes ☐ No If yes, effective date _____			

Section 2: Spouse or state-registered domestic partner information *(if applying)*

Social Security number	Last name (as appears on Medicare card)	First name	Middle initial
Permanent residential or mailing address		Date of birth	Sex ☐ M ☐ F
City		State	ZIP Code + 4
Spouse or state-registered domestic partner's Medicare claim number from Medicare card	**Entitled to Part A (hospital)** ☐ Yes ☐ No If yes, effective date _____		
	Entitled to Part B (medical) ☐ Yes ☐ No If yes, effective date _____		

Section 3: Plan choice

I wish to enroll in:

Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)

☐ Kaiser Permanente WA Medicare Advantage PEBB Retire (HMO)
(formerly Group Health Medicare Advantage)

Kaiser Foundation Health Plan of the Northwest

☐ Kaiser Permanente NW Senior Advantage (HMO)

I wish to cancel my current medical coverage: ☐ Yes ☐ No

Name of RETIREE'S contracting primary care provider (PCP) (refer to plan's provider directory)	Current patient? ☐ Yes ☐ No
Name of SPOUSE'S or STATE-REGISTERED DOMESTIC PARTNER'S contracting primary care provider (PCP) (refer to plan's provider directory)	Current patient? ☐ Yes ☐ No

(continued)

Section 4: Medical information	Retiree	Spouse or State-Registered Domestic Partner
1. Do you currently have end-stage renal disease (kidney disease)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have any health insurance other than Medicare?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, through which company?	What type of policy?	
Do you intend to discontinue this policy?	☐ Yes ☐ No	☐ Yes ☐ No
Note: Your answers to questions #3 and #4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.		
3. Do you live in an institution?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, name of institution	Date of admission	
Address	Phone number	
4. Are you currently receiving Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, Medicaid number		

Signature and authorization

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB Program benefits as of the last day of the month we qualified. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB Program benefits.

We have read and understand this form, including the Statement of Understanding below. We know that we must refer to our plan's certificate of coverage for rules we must follow to receive coverage under this Medicare Advantage contract.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.

This form cannot be signed more than 90 days before the effective date of this coverage. (*See Statement of Understanding on the next page for Medicare Advantage Plan coverage effective date.)

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to **www.hca.wa.gov/public-employee-benefits.**

Signature of applicant	Date	Signature of spouse or state-registered domestic partner (if enrolling)	Date

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where he or she resides) on this application means that I have read and understand the contents of the 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 the Medicare Advantage plan or by Medicare.

Signature of individual who assisted the applicant and/or spouse or state-registered domestic partner in completing this form	Date

If you are the authorized representative, you must sign above and provide the following information:

Name	Relationship to applicant
Address	**Phone**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage plan will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

*I understand that my enrollment in the Medicare Advantage plan I have selected is effective the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Please contact the plans listed on the previous page if you need information in another language or format.

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of the Northwest are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.

2017 PEBB PROGRAM MEDICAL CONTRACTORS

Kaiser Foundation Health Plan of Washington
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-877-221-8221 or TTY 711

Please return this form by mail to:

Washington State Health Care Authority
P.O. Box 42684, Olympia, WA 98504-2684
or fax to: 360-725-0771