OMB No. 0938-1378
Expires: 12/31/2026

KAISER PERMANENTE®

Individual Plan

Kaiser Permanente Senior Advantage (HMO) or
Kaiser Permanente Dual Complete (HMO D-SNP)

2026 Enrollment Form

Hawaii Region Individual Plan

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a Medicare Advantage Plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have Medicare Part A (Hospital Insurance), **and**
- Have Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- In general, your coverage effective date is based on when we receive your enrollment request. If mailing, please note the postmark date is not considered the date the plan receives the request and does not determine your coverage effective date. Enrollment requests eligible for a first of the upcoming month effective date must be received by Kaiser Permanente by the last day of the month prior to that effective date.
- We will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

Have you thought about enrolling on **kp.org/enrollonline** instead? It's a fast, secure, and easy way to apply.

What happens next?

Send your completed and signed form to:

Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

You can also FAX or EMAIL your completed form to:
FAX: **1-855-355-5334**
EMAIL: **KPMedicareEnrollments@kp.org**

- We'll review your form to make sure it's complete.
- We'll let Medicare know that you've applied for a Kaiser Permanente Medicare Individual Health Plan.
- Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send you a Kaiser Permanente ID card and information for new members.
- You can check the progress of your application online at **kp.org/medicare/applicationstatus**.

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How do I get help with this form?

Call Kaiser Permanente at **1-800-805-2739**.
TTY users can call **711**.

En español: Llame a Kaiser Permanente al
1-800-805-2739/TTY **711**.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

IMPORTANT
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Name

Kaiser Permanente Medical/Health Record Number (for current or former members)

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

OAHU:

- ☐ Kaiser Permanente **Dual Complete Oahu** (HMO D-SNP) - $0 per month
  Special Needs Plan (SNP) - For people who are entitled to both Medicare and **state Medicaid** benefits
- ☐ Kaiser Permanente Senior Advantage **Basic** (HMO) - $42 per month
- ☐ Kaiser Permanente Senior Advantage **Enhanced** (HMO) - $160 per month

MAUI*:

- ☐ Kaiser Permanente **Dual Complete Maui** (HMO D-SNP) - $0 per month
  Special Needs Plan (SNP) - For people who are entitled to both Medicare and **state Medicaid** benefits
- ☐ Kaiser Permanente Senior Advantage **Maui** (HMO) - $181 per month

HAWAII ISLAND*:

- ☐ Kaiser Permanente Senior Advantage **Hawaii Island** (HMO) - $188 per month

*Counties with an asterisk are only partly covered by our service area. If you live in a partly covered county, please refer to the Summary of Benefits for a list of zip codes in our service area.

Advantage Plus (optional supplemental benefits package):
Would you also like to add Advantage Plus to your Kaiser Permanente Senior Advantage plan? The Advantage Plus package is optional. For an additional **$46** per month, you can add more benefits (comprehensive dental, vision, and hearing coverage). The monthly premium for Advantage Plus will be added to your Kaiser Permanente Senior Advantage monthly premium.
Note: This option is not available under the Dual Complete (HMO D-SNP) plans.

☐ Yes ☐ No

Name

LAST Name:

Sex:
☐ Male ☐ Female

FIRST Name:

Middle Initial:

Birth Date: (mm/dd/yyyy)

Primary Phone Number:

Secondary Phone Number:

E-mail Address:

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County:

State:

ZIP Code:

Mailing Address, if different from your permanent address (PO Box allowed):

Street Address:

City:

State:

ZIP Code:

Your Medicare information:

Medicare Number:

Name

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente?
   ☐ Yes ☐ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage:

   ID # for this coverage:

   Group # for this coverage:

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   If "yes," please provide your Medicaid number:

Please Read This Important Information

If you currently have health coverage from an employer or union, joining a Kaiser Permanente Individual Medicare health plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join an Individual Medicare health plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Advantage Plus optional supplemental benefits conditions of enrollment

If you checked "Yes" to add the Advantage Plus optional supplemental benefits package on page 1, please read the information below.

By completing this enrollment application:

- I agree to adding the Advantage Plus optional supplemental benefits package that gives me comprehensive dental, vision, and hearing coverage for **$46** per month, which is in addition to my Medicare and Kaiser Permanente Senior Advantage premiums.
- I understand that the optional supplemental benefits package adds more benefits to my Kaiser Permanente Senior Advantage coverage and is subject to the terms and conditions stated in the Kaiser Permanente Senior Advantage **Evidence of Coverage.**
- I understand that the Advantage Plus optional supplemental benefits package is only available to members enrolled in a Kaiser Permanente Senior Advantage Individual Plan.
- I understand that I can disenroll from Advantage Plus coverage at any time. If I disenroll, I will not be eligible to enroll again until the following times: 1) between October 15 and December 31, for coverage to become effective on January 1; 2) between January 1 and March 31, or; 3) within 30 days of when I make a Kaiser Permanente Senior Advantage plan change during another Special Enrollment Period for coverage effective the first of the month following receipt of the request.

Name

IMPORTANT: Read and sign below:

- Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I must keep both Hospital (Part A) and Medical (Part B) to stay in Kaiser Permanente.
- By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that Kaiser Permanente will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Kaiser Permanente coverage begins, Kaiser Permanente Health Plan doctor(s) and affiliated network providers will be my primary source for my medical and prescription drug benefits. This means that when my Kaiser Permanente coverage begins, all of my health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a practitioner in the Kaiser Permanente network unless my plan has an out of network benefit or component as described in the **Evidence of Coverage** document (also known as a member contract or subscriber agreement). Benefits and services provided by Kaiser Permanente and contained in my Kaiser Permanente **Evidence of Coverage** document will be covered. Neither Medicare nor Kaiser Permanente will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Enrollee or Authorized Representative Signature: **Today's Date:**

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:

Name:

Address:

Phone Number:

Relationship to Enrollee:

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente - Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

Name

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

For HMO D-SNP enrollees:

☐ Chinese ☐ Ilocano ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Kaiser Permanente at **1-800-805-2739** if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, phone, or online each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit or you may get a bill from Medicare (or the RRB). DON'T pay Kaiser Permanente the Part D-IRMAA.

Please select a premium payment option: If you don't select a payment option, you will default to paying your invoice by mail, phone, or online. You will receive an invoice for either payment option selected. If you do not want to receive an invoice, log onto kp.org to update your preferences to paperless billing.

☐ Pay monthly by mail, phone, or online.

After you receive your first bill, you can choose a different payment option.

- You can have your monthly payment automatically deducted from your bank account. Please call us at **1-877-578-2700** (TTY **711**) to request a Medicare Autopay Selection Form or if you have any questions.
- To pay by credit or debit card, visit **kp.org/payonline** or call us at **1-877-578-2700** (TTY **711**). You will need your account information from your bill to make a payment.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

Name

Medicare Prescription Payment Plan for Part D enrollees:

If you are enrolling into a Medicare Advantage plan that includes Part D prescription drug coverage, also known as a Medicare Advantage Prescription Drug (MAPD) plan, you are eligible to participate in the Medicare Prescription Payment Plan.

Would you like to participate in the **Medicare Prescription Payment Plan**?

- The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan by spreading them across the calendar year (January–December).
- **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**
- This payment option **might** not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP).
- For more information about the Medicare Prescription Payment Plan, visit **kp.org/seniormedrx**.

☐ Yes ☐ No

Medicare Prescription Payment Plan terms and conditions

If you elected to participate in the Medicare Prescription Payment Plan:

- I understand checking "Yes" on this form is a request to participate in the Medicare Prescription Payment Plan. Kaiser Permanente will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Kaiser Permanente will let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.
- I understand that if I stay in the same health or drug plan, Kaiser Permanente will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Kaiser Permanente to opt out.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Do not complete this section if you are the enrollee or their legal/authorized representative.

Name: Relationship to enrollee:

Signature:

National Producer Number (Agents/Brokers only):

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Name

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #: Effective Date of Coverage:

ICEP/IEP: AEP: SEP (type):

Name

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.

Name

☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____ .

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____ .

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ I am in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

☐ I am in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.

☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).

☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1–March 31 each year). I want to join a Medicare Advantage Plan with drug coverage.

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on (insert date) _____ .

If you are eligible for an enrollment period that is not listed above, you can proceed without making a selection. Kaiser Permanente may contact you to verify your enrollment period if one is not apparent. If you're not sure or have questions about enrollment periods, please contact Kaiser Permanente at **1-800-805-2739** (TTY users should call **711**) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. to 8 p.m.