Advantage Plus Enrollment Form

Mid-Atlantic States Region

Thank you for your interest in our Advantage Plus plan. Combining the benefits of Advantage Plus with your Kaiser Permanente Medicare Advantage (HMO) plan can enhance your health and well-being. Please read all pages of this enrollment form carefully before signing.

Enrollment periods

The Advantage Plus optional supplemental benefits package is **only** available to members who are enrolled in or have recently applied for a Kaiser Permanente Medicare Advantage (HMO) Individual Plan.

- **New Medicare Advantage member:** If you are a new Kaiser Permanente Medicare Advantage member, you can add Advantage Plus within 30 days of your Medicare Advantage effective date.
- **Existing Medicare Advantage member:** If you already have Kaiser Permanente Medicare Advantage, you can sign up for Advantage Plus from October 15, 2021, until March 31, 2022 (your enrollment form must be received in our office by this date).

How to enroll in Advantage Plus

Online: You can complete the entire enrollment process online. Enrolling is fast and easy at **kp.org/advantageplus**.

Mail: To enroll by mail, complete and mail pages 3 and 4 of this form.

Please keep a copy of this form for your records. Do not send cash or check. You will be billed.

If you have questions, please call us at **1-888-777-5536** (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

Return the 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: 8553555334@fax.kp.org

Important information: Print in CAPITAL LETTERS and use blue or black ink only. Fill in check boxes with an "X" to mark your responses.

A. Plan benefits

The Advantage Plus supplemental benefits package includes comprehensive dental, hearing, and eyewear coverage for **$25** per month. A **$25** monthly premium for Advantage Plus benefits will be added to your Kaiser Permanente Medicare Advantage monthly premium.

B. Subscriber information

Last name

First name | MI | Gender ☐ Male ☐ Female

Kaiser Permanente medical/health record # | Medicare number (found on your Medicare card)

Home phone number | Mobile phone number | Date of birth (mm/dd/yyyy)

Permanent residence street address (P.O. box is not allowed)

City | State | ZIP code

Mailing address, if different from permanent residence (P.O. box is OK)

City | State | ZIP code

Email address

Subscriber name

C. Conditions of enrollment

By completing this application form:

- I agree to adding the Advantage Plus optional supplemental benefits package that gives me comprehensive dental, hearing, and eyewear coverage for **$25** per month, which is in addition to my Medicare and Kaiser Permanente Medicare Advantage premiums.
- I understand that the Advantage Plus optional supplemental benefits package is only available to members enrolled in a Kaiser Permanente Medicare Advantage Individual Plan.
- I understand that the optional supplemental benefits package supplements my Kaiser Permanente Medicare Advantage coverage and is subject to the terms and conditions stated in the Kaiser Permanente Medicare Advantage **Evidence of Coverage**.
- 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 next Advantage Plus annual election period for coverage effective January 1 or I have another Special Enrollment Period.
- 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 (including the "Conditions of enrollment" section above). 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.

Signature

Today's date (mm/dd/yyyy)

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

Name

Address

City

State

ZIP code

Phone number

Relationship to member