Advantage Plus Enrollment Form

Mid-Atlantic States Region

Thank you for your interest in our Advantage Plus plans. Combining the benefits of Advantage Plus with your Kaiser Permanente (HMO/HMO-POS) 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 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, 2024, until March 31, 2025 (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.

- 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: **KPMedicareEnrollments@kp.org**
- You can check the progress of your application online at **kp.org/medicare/applicationstatus**.

If you have questions, please call us at **1-888-777-5536** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

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

☐ **Advantage Plus Option 1:** includes comprehensive dental ($500 total annual allowance with 50% coinsurance), hearing ($1,000 allowance per ear, every 3 years), and eyewear coverage ($275 allowance every 2 years) for **$18** per month to be added to your Kaiser Permanente Medicare Advantage monthly premium.

☐ **Advantage Plus Option 2:** includes additional comprehensive dental coverage ($1,000 total annual allowance with 50% coinsurance) for **$23** per month to be added to your Kaiser Permanente Medicare Advantage monthly premium.

☐ **Advantage Plus Options 1 and 2:** includes additional comprehensive dental ($1,500 total annual allowance with 50% coinsurance), hearing ($1,000 allowance per ear, every 3 years), and eyewear coverage ($275 allowance every 2 years) for **$41** per month to 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 (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

City | State | ZIP code

Mailing address, if different from permanent residence (PO box is OK)

City | State | ZIP code

Email address

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

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 **1-888-777-5536** 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.**

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 additional benefits for an additional premium, 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 that I have selected adds more benefits to 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 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 Medicare Advantage plan change during another Special Enrollment Period for coverage effective the first of the month following receipt of the request.
- 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.

Enrollee or Authorized Representative Signature

Today's date (mm/dd/yyyy)

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

City

State

ZIP code

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.