MEDICARE ADVANTAGE UNIVERSAL ENROLLMENT/ ELECTION FORM FOR KAISER SENIOR ADVANTAGE

UBEN 127 (R12/18) University of California Human Resources

Mail second white copy to: RASC
P.O. Box 24570
Oakland, CA 94623-1570

OR fax to: 800-792-5178

This Enrollment/Election Form has been sent to you because you or an eligible family member has enrolled in Kaiser Senior Advantage, a Medicare Advantage plan which requires you to assign your Medicare to your plan. Please print clearly using a blue or black ballpoint pen. **Each person on Medicare must complete a separate form.**

- "Subscriber" means the University of California retiree who is carrying the medical insurance through UC.
- "Requested Effective Date" is the first of **the month after your plan receives the signed and completed form** and no earlier than the month the person becomes eligible for and enrolls in Medicare Parts A and B. (Forms submitted 90 days or more before the Medicare Part B Effective Date will be denied.)

Read the entire agreement before you sign the form.

Top white copy—send to plan: Kaiser Permanente
Attn: UC AAR—Spec Accts 4th Floor 4J
3840 Murphy Canyon Road
San Diego, CA 92123

Second white copy—send or fax to UC at address/fax above. **Yellow copy**—keep for your records.

For help with this form, call the UC Retirement Administration Service Center (1-800-888-8267) or your location's Health Care Facilitator; for the contact list, visit: ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html

To receive information in a language other than English or in another format, call Kaiser 1-800-443-0815 (TTY 711), 7 days per week, 8 a.m–8 p.m.

FORM QUESTION	WHAT TO ENTER
Requested Effective Date	If you leave the date blank, your plan will assign the first of the month you are eligible for and enrolled in Medicare, and that they are in receipt of this completed form.
Desired Contracting Medical Group	Leave blank.
Desired Contracting Physician	Leave blank.
Medical Group/Physician No.	Input if known. If not, leave blank.
Last Name, First Name, MI	Name of the person enrolling. If spouse, enter spouse's name.
Permanent Residence Address, City, State, Zip	Address of enrollee. No P.O. Boxes accepted—need street address.
Social Security Number (SSN) and Date of Birth	Enter SSN and birthdate for enrollee.
Are you the Subscriber?	Answer Yes, if the enrollee is the UC retiree/survivor. No, if not.
Subscriber's Name and SSN	Enter the UC retiree's full name and SSN. **This is very important.**
Medicare Card	Enter all numbers, letters and dates from enrollee's Social Security award letter, **red/white/blue** Medicare card **OR send a copy of the card to UC**. **This is very important.**
Question 2 Are you covering a spouse or dependent?	Answer Yes if enrollee is the UC retiree/survivor and is covering family members.
Question 3 Do you or your spouse work?	Answer Yes if enrollee or UC retiree is employed and eligible for any health insurance benefits elsewhere as an employee.
Question 5 Have other drug coverage?	Answer Yes if enrollee has another non-UC prescription drug plan, separate from UC insurance. No, if none.
Signature and Date	Enrollee must sign and date here. **This is very important.**
Authorized Representative's Signature plus Name, Address, Phone, Relationship to enrollee	If the enrollee did not sign, the person legally responsible to sign for him/her should sign and date here. **This is very important.**

Your medical plan and UC must both receive this form before your Medicare Advantage coverage and any Part B reimbursements can begin.

UNIVERSITY OF CALIFORNIA Human Resources

Medicare Advantage Universal Enrollment/Election Form
California Group Plan

Medicare Advantage Plan you are requesting enrollment in:
KAISER SENIOR ADVANTAGE

Employer Group Name (required):	Group # (Plan to complete)	Requested Effective Date: (subject to CMS approval)
University of California	KN–603624 KS–102624	
Desired Contracting Medical Group: (if applicable) N/A	Desired Contracting Physician: (if applicable) N/A	Medical Group/Physician No.: (if applicable)

Last Name:	First Name:	MI:	Sex: ☐ M ☐ F

Permanent Residence Address (Street Address Only—No P.O. Box):

City: State: ZIP: County:

Mailing Address if Different (Street, City, State, ZIP):

Daytime Phone Number (including area code):	E-mail address (optional):
Evening Phone Number (including area code):	
Social Security Number (SSN):	Date of Birth:

Are you the Subscriber? ☐ Yes ☐ No
If no, provide Subscriber Name and Social Security Number (your group may require this information)

Subscriber Name: _____ Subscriber SSN: __ __ __-__ __- __ __ __ __

Please Provide Your Medicare Insurance Information
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.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_ _/_ _/_ _ _ _
MEDICAL (Part B)	_ _/_ _/_ _ _ _

You must have Medicare Parts A and B to join a Medicare Advantage plan.

1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year): _____ /_____ /_____

If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer plan? ☐ Yes ☐ No

If yes, name of spouse: _____

Name of dependents: _____

3. Do you or your spouse work? ☐ Yes ☐ No

4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs.
Will you have other prescription drug coverage? ☐ Yes ☐ No
If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: _____

ID # for Coverage: _____

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If yes, please provide the following information:

Name of Institution: _____

Address of Institution (number and street): _____

Phone Number of Institution: (_____) _____ - _____

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

By completing this enrollment application, I agree to the following:
This health plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to the health plan or by calling **1-800-MEDICARE (1-800-633-4227** or TTY **1-877-486-2048)**, 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage plan because I can be enrolled in only one Medicare Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Medicare Advantage plan.

I understand that this Medicare Advantage Plan serves a specific service area. If I move out of the area that the Medicare Advantage Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the **Evidence of Coverage** document from the Medicare Advantage Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date the Medicare Advantage Plan coverage begins, I must get all of my health care from this Medicare Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by this Medicare Advantage Plan and other services contained in my **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THIS MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

RELEASE OF INFORMATION:
By joining this Medicare Health Plan, I acknowledge that the Medicare Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this Medicare Health Plan will release my information, including any 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/election 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 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.

KAISER PERMANENTE ARBITRATION AGREEMENT: I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims procedure regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature: _____ Date: _____

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

Name (please print): _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____