MEDICARE ADVANTAGE UNIVERSAL ENROLLMENT/ELECTION FORM FOR KAISER SENIOR ADVANTAGE

UBEN 127 (R12/24) University of California Human Resources

Complete form in ink and send to:
UC RASC
P.O. Box 24570
Oakland, CA 94623-1570
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 that requires you to assign your Medicare to your plan.

Each person on Medicare must complete a separate form. Please print clearly using a blue or black ballpoint pen.

- Read the entire agreement before you sign the form.
- Include a copy of your Medicare card with each form.
- Check the box accepting Kaiser's arbitration terms on page 3.
- Sign and date your form. Electronic signatures are acceptable, typed are not.
- Send white copy to UC by mail or fax. Keep yellow copy for your records.
- Need help? Call the UC Retirement Administration Service Center (800-888-8267) or your location's Health Care Facilitator; for the contact list, visit: ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html.
- Need information in a language other than English or in another format? Call Kaiser 1-800-443-0815 (TTY 711), 7 days per week, 8:00 a.m.–8:00 p.m.

"Subscriber" is typically the University of California retiree who is carrying the medical insurance through UC.

"Enrollee" is the person assigning/coordinating his or her Medicare. An enrollee can be the UC retiree/survivor, the spouse/domestic partner or another family member on Medicare.

"Requested Effective Date" is the **first of the month after UC 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 can be submitted 60 to 90 days before your Medicare Part B Coverage Start Date.)

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

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 UC is in receipt of this completed form.
Medical Group/Physician No.	Input if known. If not, leave blank.
Name	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 birth date 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 and Medicare Number (This is the 11-digit alpha-numeric number that replaced your SSN.)	Enter all numbers, letters and dates from your **red/white/blue** Medicare card **OR send a copy of the card** or your award letter from Social Security or the Railroad Retirement Board 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 4 Have other drug coverage?	Answer Yes if enrollee has another non-UC prescription drug plan, separate from UC insurance. Check your ID card or a prescription container for your ID number. No, if none.
Checkbox, Signature and Date	Check the box, 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.

TO BE ENROLLED, FORM MUST BE SIGNED AND DATED, AND ARBITRATION TERMS ACCEPTED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

UNIVERSITY OF CALIFORNIA Human Resources

Medicare Advantage Universal Enrollment/Election Form
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:	Gender: ☐ M ☐ F

Permanent Residence 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: County:

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

Daytime Phone Number (including area code):	Email 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:	Coverage Start Date:
HOSPITAL (Part A)	_ _ / _ _ / _ _ _ _
MEDICAL (Part B)	_ _ / _ _ / _ _ _ _

You must have Medicare Part B; however, most employer groups require both 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(s) of dependent(s): _____

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

4. Some individuals may have other drug coverage, in addition to the drug coverage in their current plan, including other private insurance, Workers' Compensation, VA benefits or state pharmaceutical assistance programs.

Will you have other **prescription** drug coverage? ☐ Yes ☐ No

Name of other coverage: _____

ID Number for coverage: _____

5. 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: _____

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term: _____

☐ **I choose not to answe**r

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual

☐ I use a different term: _____

☐ **I choose not to answer**

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

ARBITRATION AGREEMENT for Kaiser Foundation Health Plan – California:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care 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.

☐ **By checking this box I am signing and accepting the above arbitration terms PERTAINING TO KAISER FOUNDATION HEALTH PLAN.**

Signature: _____ Date:_____

(Electronic signatures, e.g., Adobe, DocuSign or Microsoft signatures, are acceptable; not typed)

This health plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B; however, most employer groups require both 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 during the year as allowed by my group by sending a request to the health plan. 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 receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan.

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 my 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 where 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.

Signature: _____ **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 (please print): _____

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.

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): _____