

# KAISER PERMANENTE ACCOUNT CHANGE FORM

Please print or type in black or dark blue ink only. Make a copy for your records and use as a temporary ID.

<b>A. TO BE COMPLETED BY REALCARE</b>				
California Association of REALTORS				
				Enrollment Unit Number (EU)
				Fax Number
<b>B. SUBSCRIBER INFORMATION (Please complete all fields)</b>				
CA Real Estate License # _____				
Last Name		First Name		MI
Medical Record Number				
Home Address		City		State ZIP Code
<input type="checkbox"/> Check here if new home address				
Billing Address		City		State ZIP Code
<input type="checkbox"/> Check here if new billing address				
Social Security Number		Home Phone		Business Phone
		Cell Phone		Email Address
<b>C. REQUESTED CHANGE(S)</b>				
<input type="checkbox"/> Address Change (Complete Section B)		<input type="checkbox"/> Add Dependent (Complete Sections B and F)		
<input type="checkbox"/> Name Change (Complete Sections B and E)		<input type="checkbox"/> Delete Dependent (Complete Sections B and F)		
		<input type="checkbox"/> Open Enrollment/Change Plan (Complete Sections B, D and F)		
<b>D. <input type="checkbox"/> TRANSFER MY COVERAGE</b> <input type="checkbox"/> \$5 Plan <input type="checkbox"/> \$15 Plan <input type="checkbox"/> \$20 Plan <input type="checkbox"/> \$30 Plan <input type="checkbox"/> \$50 Plan <input type="checkbox"/> \$0/1,500 Plan <input type="checkbox"/> \$30/1,000 Plan <input type="checkbox"/> \$30/1,500 Plan				
<b>E. NAME CHANGE</b>				
From:		To:		
Last Name		First Name		MI
		Last Name		First Name
				MI
<b>F. LIST FAMILY MEMBERS TO BE ENROLLED/DELETED (Please attach additional sheet, if adding more than three dependents.)</b>				
Have any dependents ever been Kaiser Permanente members? If so, please indicate their Medical Record Number in the field below.				
<b>Spouse/Domestic Partner</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete				
		Medical Record No.		Social Security No.
Last Name		First Name		MI
Date of Birth ____/____/____		Event Date ____/____/____		Effective Date ____/____/____
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				Maiden/Other Name
				<input type="checkbox"/> Spouse
				<input type="checkbox"/> Domestic Partner
<b>Dependent 1</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete				
		Medical Record No.		Social Security No.
Last Name		First Name		MI
Date of Birth ____/____/____		Event Date ____/____/____		Effective Date ____/____/____
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				Relationship
				<input type="checkbox"/> Child <input type="checkbox"/> Student
<b>Dependent 2</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete				
		Medical Record No.		Social Security No.
Last Name		First Name		MI
Date of Birth ____/____/____		Event Date ____/____/____		Effective Date ____/____/____
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				Relationship
				<input type="checkbox"/> Child <input type="checkbox"/> Student
<b>Dependent 3</b> <input type="checkbox"/> Add <input type="checkbox"/> Delete				
		Medical Record No.		Social Security No.
Last Name		First Name		MI
Date of Birth ____/____/____		Event Date ____/____/____		Effective Date ____/____/____
				<input type="checkbox"/> Male <input type="checkbox"/> Female
				Relationship
				<input type="checkbox"/> Child <input type="checkbox"/> Student
<b>G. CERTIFICATION FOR STUDENTS OVER AGE 18:</b> I hereby certify that my dependent(s) is/are currently enrolled as a full time student(s) at the school(s) listed below.				
Name: _____		# of Units: _____		Name: _____
School Name: _____		Address: _____		School Name: _____
				Address: _____
<b>Dependent(s)' Address (if different from subscriber's):</b> <input type="checkbox"/> Check here if all dependents are at the address below.				
Name(s)		Address		City
				State
				ZIP Code

**H. Kaiser Foundation Health Plan Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

Employee or C.A.R. Member    Signature \_\_\_\_\_    Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ***Kaiser Application Checklist***

- ✓ Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- ✓ Enclose initial month's premium payment (**even if you are selecting the Automatic Premium Payment option**). Include premiums for all applicable insurance plans (medical, dental, vision, and life insurance).
- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ If you are choosing the Automatic Premium Payment method, enclose a **voided check** and complete the form below and return to RealCare with your initial premium check. **The initial premium must be submitted even if you select the Automatic Premium Payment option.**
- ✓ Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- ✓ Have questions or need assistance? Call 1-800-939-8088 Ext. 202

**Mail Applications to:  
RealCare Insurance Marketing, Inc.  
19310 Sonoma Hwy. Ste. A  
Sonoma, CA 95476**

**MONTHLY CHECKING/SAVINGS ACCOUNT  
AUTOMATIC PREMIUM PAYMENT AUTHORIZATION**

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

Automatic premium payments will be debited from my account on the date that dues/premiums are due. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium, dues and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

<b><i>Policyholder Information</i></b>	
Policyholder name: _____	Phone: _____
Social Security Number: _____	Email Address: _____

**PLEASE  
ATTACH A  
COPY OF  
YOUR VOIDED  
CHECK AND  
SUBMIT WITH  
YOUR  
ENROLLMENT  
APPLICATION.**

<b><i>Banking Information</i></b>	
Name of bank or financial institution: _____	
Bank Account Name: _____	
<input type="checkbox"/> Checking Account	<input type="checkbox"/> Savings Account
Account Number: _____	
Bank Routing Number: _____	

<b><i>Authorized Signature</i></b>	
_____	Date: _____
<b>Authorized Signature</b> <i>(As it appears in the financial institution's records)</i>	



# C.A.R. HEALTH PLAN CHANGE OF COVERAGE INSTRUCTIONS

For Assistance, Call RealCare Insurance Marketing at (800) 939-8088

## Step 1: Review Plan Options

### Visit RealCare Member Website

Review the available medical, dental, vision and life insurance plans and rates at the RealCare Member website – [www.RealCareOnline.com](http://www.RealCareOnline.com). Links to benefit details and rates for all alternative plans or coverage options are available online. During the Open Enrollment you may add or drop coverage, change plans or add or drop dependents. Once you've decided which plans you want and who you want to cover, use the worksheet below to calculate the difference in premium. All eligible changes made during Open Enrollment will become effective January 1<sup>st</sup> 2010.

## Step 2: Calculate Difference in Premium

**You may be required to submit a payment with your completed change forms. Use the worksheet below to calculate the amount that may be due for changes effective 1/1/2010:**

<b>New Medical Premium</b>	\$
<b>New Dental Premium</b>	\$
<b>New Vision Premium</b>	\$
<b>Life Premium * (Only if currently enrolled)</b>	\$
<b>Monthly Administration Fee **</b>	\$ 20.00
<b>Total New Monthly Payment effective</b>	\$
<b>Current Monthly Payment (including administration fee)</b>	-
<b>Difference in Premium (<i>Keep a copy for your records</i>)</b>	\$
<b>If submitting application or change form for ANTHEM BLUE CROSS AFTER November 30<sup>th</sup> 2009, multiply Difference in Premium <i>times two</i> and submit this amount with your completed forms.</b>	\$
<small>* Life Insurance is guaranteed only for new members who elect coverage between their 60<sup>th</sup> and 120<sup>th</sup> day of membership and who have not been hospitalized within the 90 days prior to making application. Eligible members who wish to enroll outside of the initial eligibility date, or who have been hospitalized in the 90 days prior to making application may apply for coverage and will be medically underwritten. Coverage will not be guaranteed for these applicants.  ** Administration fee \$20 per month. Fee is lower if subscriber does not enroll in medical insurance.</small>	

## Step 3: Complete Required Forms

You may be required to complete more than one form in order to make the changes you want. Please call RealCare at (800) 939-8088, Ext. 202 if you are unsure about which forms are needed.

## Step 3: Submit Completed Forms and Payment (if required)

- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ Check your forms to be sure they are complete and have been signed

[www.RealCareOnline.com](http://www.RealCareOnline.com)

**Mail Completed Application/s  
and Payment To:**

**REALCARE INSURANCE MARKETING, INC.**  
19310 Sonoma Highway, Ste. A  
Sonoma, CA 95476