ACCOUNT CHANGE FORM
FOR KAISER PERMANENTE HEALTH CARE PLANS

Submit Completed Form to RealCare:
Via Fax: (707) 939-8450 OR Via Email: rc-enrollment@nfp.com
Via Mail: 548 Market St. PMB 91266, San Francisco CA 94104

A. TO BE COMPLETED BY REALCARE
Company: **California Association of REALTORS®** Purchaser#:_____ (EU)#: _____
Purchaser Contact: RealCare Insurance Marketing, Inc. Phone: (800) 939-8088 Fax: (707) 939-8450

B. SUBSCRIBER INFORMATION (Please Complete all fields) _____ _____
CA Real Estate License # Medical Record #

_____ _____-_____-_____
Last Name First MI Social Security Number

_____ _____ _____ _____
Home Address City State ZIP Code

_____ _____ _____ _____
Mailing Address City State ZIP Code

_____ _____ _____ _____
Home Phone Work Phone Cell Phone Email Address

C. REQUESTED CHANGE(S) Reason: ☐Open Enrollment ☐Other ☐Qualifying Event Event Type: _____

Requested Effective Date: _____ **Event Date:** _____

☐ **Address Change** (Complete Section B) ☐ **Name Change** (Complete Sections B and E) ☐ **Add Dependent** (Complete Sections B and F)
☐ **Delete Dependent** (Complete Sections B and F) ☐ **Plan Change** (Complete Sections B, D and F)

D. PLAN CHANGE: ☐Bronze HDHP HSA 6650/0% ☐Bronze 5800/60 ☐Silver HSA 2850/25% ☐Silver 2900/65 ☐Silver 2300/65
☐Silver 2500/55 ☐Silver 1900/65 ☐Gold 2250/35 ☐Gold 1000/40 ☐Gold HDHP HSA 1750/15% ☐Gold 250/35 ☐Gold 0/35
☐Plat 250/30 ☐Plat 0/20 ☐Plat 0/10

E. NAME CHANGE:

From:_____ To:_____
Last Name First Name M.I. Last Name First Name M.I.

F. DEPENDENTS TO BE ENROLLED/DELETED (Please attach additional sheet, if adding more than three dependents.) Have any dependents ever been Kaiser Permanente members? If so, please indicate their Medical Record Number in the field below. Dependent children may be covered up to age 26 and may be married and not attending school full-time. A dependent child who has access to other employer-sponsored health coverage is not eligible under this plan.)

SPOUSE/DOMESTIC PARTNER ☐Add ☐Delete ☐Male ☐Female ☐Spouse ☐Domestic Partner

_____
Last Name First Name M.I.

_____/_____/_____ _____ _____ _____
Date of Birth Medical Record No.(If known) Social Security No Maiden/Other Name

DEPENDENT ☐Add ☐Delete ☐Male ☐Female ☐Spouse ☐Domestic Partner

_____
Last Name First Name M.I.

_____/_____/_____ _____ _____ _____
Date of Birth Medical Record No.(If known) Social Security No Maiden/Other Name

DEPENDENT ☐Add ☐Delete ☐Male ☐Female ☐Spouse ☐Domestic Partner

_____
Last Name First Name M.I.

_____/_____/_____ _____ _____ _____
Date of Birth Medical Record No.(If known) Social Security No Maiden/Other Name

To the best of my knowledge and belief, all information on this form is correct and true.

Kaiser Foundation Health Plan Arbitration Agreement:

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 can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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 KFHP, 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 contained in the *Evidence of Coverage*.

Employee/Subscriber Signature Required _____ **Date** _____