Kaiser Permanente Senior Advantage/Medicare Advantage for Federal Members (HMO)
Senior Advantage 2/Medicare Advantage 2 Enrollment Application

☐ NCAL ☐ NCAL-Fresno ☐ SCAL ☐ Colorado ☐ Georgia ☐ Hawaii ☐ Mid-Atlantic States ☐ Northwest

The FEHB enrollee (employee or retiree) must complete this form. By enrolling in Senior Advantage 2/Medicare Advantage 2, you and your covered dependents enrolled in Kaiser Permanente Senior Advantage/Medicare Advantage for Federal Members will be eligible to receive reimbursement of your Medicare Part B premium as described in the Senior Advantage 2/Medicare Advantage 2 Program Description. You must provide the enrollee's information below and the name(s) and Social Security number(s) for each dependent enrolled in Senior Advantage/Medicare Advantage for Federal Members.

FEHB enrollee

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

Street address

City | State | ZIP code | Telephone number

Dependent 1

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

Dependent 2

Last name | First name | MI

Kaiser Permanente medical/health record number | Date of birth (mm/dd/yyyy) | Social Security number (SSN)

I understand that my signature on this application means that I have read, understand, and agree to the plan rules outlined in the Senior Advantage 2/Medicare Advantage 2 Program Description and FEHB Brochure. I am the enrollee and agree to enroll in the Program myself and/or any eligible dependents who have Senior Advantage/Medicare Advantage.

FEHB enrollee's signature or authorized representative* | Today's date (mm/dd/yyyy)

*If authorized representative, attach copy of legal documentation, such as Power of Attorney form

Mail to: Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

Email: KPMedicareEnrollments@kp.org
Fax: 1-855-355-5334