KAISER PERMANENTE®

Bridge Program Account Change Form

What is this form for?

Use this form if you need to make changes to your Kaiser Permanente Bridge Program account, which provides help in paying your health plan premiums and out-of-pocket costs. This form is not for applying for coverage in Kaiser Permanente's GA Gold 500/20 plan.

Do I need to use this form?

Not all changes to your account need to be made using this form. Some changes you can also request by phone.

Please see the guidelines below for which changes must be made using this form, and what parts you need to fill out. To make changes by phone, please call the Member Service Contact Center at **888-865-5813,** Monday through Friday, 7 a.m. to 7 p.m. Eastern time (ET). TTY users call **711.**

Type of change	How you can request the change	If you use the form, fill out these parts:
Update my contact information	By phone or by using this form	A, B, G
Change a name	Using this form, plus supporting documentation	A, C, G
Remove a dependent from my account	By phone or by using this form	A, D, G
Cancel membership for everyone on account	By phone or by using this form	A, E, G
Add a dependent to my account	Using this form, plus supporting documentation	A, F, G Proof of triggering event form (if making request outside of open enrollment)

How do I fill out this form?

- Complete all sections of this form that apply to your change, using black or blue ink.
- Please keep a copy of this form for your records.

Where do I send the form?

Return completed forms, and any required supporting documentation, to:

California Service Center
Attn: CHC
P.O. Box 939095
San Diego, CA 92193

You may also fax this form, and any required supporting documentation, to:
866-242-0994

Questions?

We're here to help. If you have any questions about completing this form, please call the Member Service Contact Center at **888-865-5813,** Monday through Friday, 7 a.m. to 7 p.m. Eastern time (ET). TTY users call **711.**

KAISER PERMANENTE®

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Kaiser Permanente's Bridge Program

Account Change Form

Georgia

A. Fill out your information

Please select one: I'm the ☐ primary member (must be over 18) ☐ parent/guardian (if primary member is under 18)

First name MI

Last name

Health record number (if any)

Date of birth (mm/dd/yyyy) / /

Gender: ☐ Male ☐ Female

B. Update contact information

Fill out any information that's changed.

Mailing address

City State ZIP code

Home address, if different from mailing address (no P.O. boxes, please)

City State ZIP code

Email Phone - -

Written language preference

Spoken language preference

C. Change a name

Whose name is changing? ☐ Child ☐ Spouse/domestic partner ☐ Primary member

Old name

First name MI

Last name

New name

First name MI

Last name

Enter primary applicant's name

D. Remove a dependent from my account

If you're removing more than 2 dependents, make a copy of this page before filling it out and attach it with the form.

Dependent 1

First name MI

Last name

Health record number Date of birth (mm/dd/yyyy) / /

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

Dependent 2

First name MI

Last name

Health record number Date of birth (mm/dd/yyyy) / /

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

E. Cancel membership for everyone on account

☐ Please cancel membership in the Kaiser Permanente Bridge Program for everyone on this account. I understand that this will cancel enrollment in the Kaiser Permanente GA Gold 500/20 plan for everyone on this account.

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy) /

F. Add a dependent

The Bridge Program includes financial help from Kaiser Permanente. To qualify for this help, any dependent you add must meet these requirements:

- Live in the Kaiser Foundation Health Plan of Georgia, Inc., service area.
- Are between the ages of 18 and 64 and actively enrolled, students or participants, in a training program with a participating Kaiser Permanente community partner.
- Live in a household with incomes below 100% of the federal poverty level (for example, $12,060 for an individual and $24,600 for a family of 4 per 2017 guidelines).
- Are not eligible for financial assistance through the Georgia Health Insurance Exchange and do not have access to any other public or private health coverage, including, but not limited to, Medicaid, Medicare, or job-based coverage.
- Have not previously been enrolled in the Kaiser Permanente Bridge Program.

If you want to add a dependent outside of the open enrollment period:

- You must have had a triggering or qualifying life event. For a list of qualifying events, see the proof of triggering event form at the end of this form.
- **You must complete and send in the proof of triggering event form on pages 7–13 and proof of your event.**

For more information, please call the Member Service Contact Center at **888-865-5813,** Monday through Friday, 7 a.m. to 7 p.m. Eastern time (ET). TTY users call **711.**

- Please complete the information below for each dependent you want to add to your plan.
- If you want to add more than 2 dependents, make a copy of this page before filling it out and attach it to the form.

Enter primary applicant's name

F. Add a dependent *(continued)*

Dependent 1

First name MI

Last name

Health record number (if any)

Date of birth (mm/dd/yyyy) / /

Gender: ☐ Male ☐ Female

Social Security number (optional) - -

Relationship to primary member: ☐ Child ☐ Spouse/domestic partner ☐ Other _____

Is Dependent 1 ...

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident? If yes, how many years has the primary applicant been a legal permanent resident? _____	☐ Yes ☐ No
Eligible for health coverage through public programs such as Medicaid or Medicare?	☐ Yes ☐ No
Eligible for financial assistance through Georgia Health Insurance Exchange?	☐ Yes ☐ No
Currently covered through or able to be covered through a job-based health plan or another health plan?	☐ Yes ☐ No

What month do you want Dependent 1's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy) /

Enter primary applicant's name

F. Add a dependent *(continued)*

Dependent 2

First name MI

Last name

Health record number (if any)

Date of birth (mm/dd/yyyy) / /

Gender: ☐ Male ☐ Female

Social Security number (optional) - -

Relationship to primary member: ☐ Child ☐ Spouse/domestic partner ☐ Other _____

Is Dependent 1 ...

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident? If yes, how many years has the primary applicant been a legal permanent resident? _____	☐ Yes ☐ No
Eligible for health coverage through public programs such as Medicaid or Medicare?	☐ Yes ☐ No
Eligible for financial assistance through Georgia Health Insurance Exchange?	☐ Yes ☐ No
Currently covered through or able to be covered through a job-based health plan or another health plan?	☐ Yes ☐ No

What month do you want Dependent 1's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy) /

Enter primary applicant's name

G. Signature

By signing this form, I'm saying that the information I gave is true and complete.

If I give any false or incomplete information on this form or in any other communication about this form, my Kaiser Permanente Bridge Program account may be ended. I understand it's a crime to knowingly give false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, and my coverage under the Kaiser Permanente Bridge Program may be ended. Penalties may include fines, denial of insurance benefits, and imprisonment.

The primary member (if over 18) or the primary member's parent or guardian (if the primary member is under 18) must sign below. If you're adding any new dependents 18 or older, they must also sign below.

X

Signature of primary member (if 18 or older)

Date (mm/dd/yyyy)

X

Signature of parent or legal guardian (if primary member is under 18)

Date (mm/dd/yyyy)

X

Signature of new adult dependent (18 or older)

Date (mm/dd/yyyy)

Enter primary applicant's name

Proof of triggering event form

Who should use this form?

Use this form only if you're adding a dependent outside of open enrollment. Ignore pages 7–13 if you're not adding a dependent to the Bridge Program.

When do I have to send in this form?

You must submit this form and any supporting documentation to us within 60 days of your event. If we don't get your documents within 60 days of your event, you may need to wait until the next open enrollment period to add a dependent to your account.

How do I fill it out?

STEP 1: Fill out the primary applicant information.

STEP 2: Check 1 box for your triggering event and 1 box for the proof you're sending in (unless otherwise noted). Make sure the triggering event and the type of proof apply to your state.

- You only need to send in 1 type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
  - First and last name
  - Home address (no P.O. boxes)
  - Health/medical record number (if you have one)
  - Date of birth

Questions?

If you need help filling out this form, please call the Member Service Contact Center at **888-865-5813,** Monday through Friday, 7 a.m. to 7 p.m. Eastern time (ET). TTY users call **711.**

Enter primary applicant's name

STEP 1: Primary applicant information

Who is the primary applicant?

- In an individual plan, the primary applicant is the person who'll be covered by the health plan.
- If the application or Bridge Program Account Change Form is only for a child under 18, the child is the primary applicant.

First name

Last name

MI

Application ID number (if you applied online)

Social Security number (if any) - -

Phone - -

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy) / /

Health record number (if any)

Home address (no P.O. boxes)

City

State

ZIP code

Parent/legal guardian (if primary applicant is under 18)

First name

Last name

Agent/broker/producer/KPIF representative (if any)

First name

Last name

Enter primary applicant's name

STEP 2: Proof of your triggering event

Instructions:

- Check 1 box for your triggering event and 1 box for the proof you're sending in (unless otherwise noted). Make sure the triggering event and the type of proof apply to your state.
- You only need to send in 1 type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
  - First and last name
  - Health/medical record number (if you have one)
  - Home address (no P.O. boxes)
  - Date of birth

Triggering event	Type of proof
☐ **1. Loss of health care coverage** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington **Keep in mind, this event does NOT qualify as a triggering event if:** • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and do not have any other coverage. • You voluntarily ended your coverage.	**Letter from your employer** ☐ Letter or other document from your employer stating that the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date when this coverage ended or will end. ☐ Letter or document from your employer stating that the employer stopped or will stop contributing to the cost of coverage and the date when this contribution ended or will end. ☐ Letter showing your employer's offer of COBRA coverage or stating when your COBRA coverage ended or will end. **Letter from your insurer or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your health insurance company showing a coverage end date, including a COBRA coverage end date. ☐ Letter from school stating when student health coverage ended or will end. ☐ Letter or notice from Medicaid, Medi-Cal, or the Children's Health Insurance Program (CHIP) stating when Medicaid, Medi-Cal, or CHIP coverage ended or will end. ☐ Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
1. Loss of health care coverage *(continued)*	**Other** ☐ Dated military discharge papers or Certificate of Release, including the date that coverage ended or will end, if you're losing coverage because you're no longer on active military duty. ☐ Dated and signed written verification from an agent/broker/producer or dated letter from the insurer, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended. ☐ Pay stubs of both current and previous hours if a reduction in work hours caused you to lose coverage.
☐ **2. Gaining or becoming a dependent through marriage (or domestic partnership/civil union)** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	**Provide this:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.
California, Colorado, Hawaii	☐ Official government record, including date of domestic partnership or civil union registration.
☐ **3. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. ☐ Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth. ☐ Military record showing the child's birth date and place of birth. ☐ Official government record of a foreign birth certificate showing the child's birth date and place of birth. ☐ Religious record showing the child's birth date and place of birth. ☐ Letter or other document from the health insurance company, like an Explanation of Benefits, showing that services related to birth or after-birth care were given to the child, the mother, or both, including the dates of service. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a filing date stamp. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a filing date stamp. ☐ Foster care papers dated and signed by a court official.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
☐ **4. Child support order or other court order to cover a child** Georgia, Hawaii, Maryland, Oregon, Virginia, Washington **Child support order or other court order to cover a dependent** Only California, Colorado	☐ Signed court order with court filing date stamp.
☐ **5. Permanent relocation** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington **In this instance, you move from a non–Kaiser Permanente service area to a Kaiser Permanente service area, or you move from a foreign country or a United States territory.**	**Provide this:** ☐ Proof of minimum essential coverage from your old insurer for at least 1 full day in the last 60 days (applicants moving within the U.S. only). **And provide any of these: 1 with your old residential address and 1 with your new residential address (no P.O. boxes):** ☐ Lease or rental agreement. ☐ Insurance documents, like homeowner's, renter's, or life insurance policy or statement. ☐ Mortgage deed, if it states that the owner uses the property as the primary residence. ☐ Mortgage or rental payment receipt. ☐ Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card. ☐ Mail from a government agency to your address, like a Social Security statement, or a notice from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program. ☐ Your valid state ID. ☐ Internet, cable, or other utility bill (including any public utility like a gas or water bill) or other confirmation of service (including a utility hookup or work order). ☐ Telephone bill showing your address (cellphone or wireless bills are OK). ☐ Mail from a financial institution, like a bank statement. ☐ U.S. Postal Service change of address confirmation letter. ☐ Pay stub showing your address. ☐ Voter registration card showing your name and address. ☐ Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification. ☐ Naturalization papers signed and dated within the last 60 days or green card, Education Certificate, or visa (if you moved to the U.S. from another country).

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
☐ **6. Release from incarceration** Marketplace and off-marketplace: California Marketplace only: Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	☐ Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.
☐ **7. Determination by the health insurance marketplace** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	☐ Letter or notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
☐ **8. Contract violation** Colorado	☐ Written confirmation, with date, from the Division of Insurance that the health plan in which you're enrolled has substantially violated a material provision of your contract.
☐ **9. Misinformation about coverage** California	☐ Notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
☐ **10. Provider network changes** California	☐ Notice from provider stating you're eligible for a special enrollment period and showing determination date.
☐ **11. Losing a dependent through divorce or legal separation** Marketplace and off-marketplace: California, Maryland At the option of the marketplace: Colorado, District of Columbia, Georgia, Hawaii, Oregon, Virginia, Washington	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
☐ **12. Death of the subscriber or dependent** Marketplace and off-marketplace: California, Maryland At the option of the marketplace: Colorado, District of Columbia, Georgia, Hawaii, Oregon, Virginia, Washington	☐ Death certificate.
☐ **13. Change in eligibility for federal financial assistance through the health insurance marketplace** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	☐ Most recent eligibility determination from the marketplace showing determination date.
☐ **14. Change in eligibility for employer health coverage** California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating that the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date when this coverage or benefits changed or will change.

By submitting a signed application or Account Change Form and proof of your triggering event, you're saying that the triggering event happened. It's important that we get proof of your triggering event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we decide that the triggering event didn't happen, we may take legal action. The legal action may include cancelling your coverage retroactively to the day it started. You may also be responsible for the cost of any services that you got.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-888-865-5813** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-865-5813**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-888-865-5813** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-865-5813**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-865-5813** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-865-5813** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-888-865-5813** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-865-5813** (TTY: **711**).