Proof of qualifying life event form

Who should use this form?	• Use this Proof of Qualifying Life Event Form to apply directly to Kaiser Permanente if you or a dependent has had a qualifying life event. It can help you figure out which type of proof you'll need to provide for your qualifying event. ◦ **Kaiser Permanente for Individuals and Families plan members** should submit their proof along with the Account Change Form. ◦ **People who aren't Kaiser Permanente for Individuals and Families plan members** should submit their proof along with their Application for Health Care Coverage. • A qualifying life event is a change in your life that lets you apply for health care coverage outside the annual open enrollment period. This is called a special enrollment period. Examples include getting married, having a baby, or losing coverage because you lost your job. • Anyone entitled to Medicare Part A or enrolled in Medicare Part B can't enroll in individual and family plans. Do not continue to use this form. Visit **kp.org/wa/medicare** to learn more about your Medicare plan options or apply for coverage.
How to use this form	• Fill out Steps 1, 2, and 3. • Submit this form and proof of your qualifying life event with your application or Account Change Form (if applicable). See "Submitting your proof" on page 7 for details. • We must receive your proof within **30 calendar days** from the date of the special enrollment period notification letter.
When to submit your proof	We must receive your proof within **30 calendar days** from the date of the special enrollment period notification letter. If we don't get your proof in time, we'll have to cancel your application. You may apply again if you're still within your special enrollment period.
Need help?	Visit **kp.org/wa/if-sep** for more information. You can also call us at **1-800-358-8815** (for TTY, call **711**) to request a copy, or contact your producer.

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Primary applicant 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.
- In a family plan, the primary applicant is the family member on the health plan who's authorized to make changes to the account.
- If the application is only for a child under 18, the child is the primary applicant.

Please note: This isn't an application for health care coverage. To get health care coverage, you need to submit an application or Account Change Form.

First name

Social Security number (if any)

Last name

Phone

MI

Application ID number (if you applied online)

Gender:
☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Health/medical 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

Primary applicant name

STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying life event (mm/dd/yyyy)

For loss of health care coverage, the date of the qualifying life event is the last full day you were covered under your old plan.

STEP 3: Proof of your qualifying life event

Instructions:

- Check one box for your qualifying life event and one box for the proof you're sending in (unless otherwise noted).
- Send in one 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 any)
  - Home address (no P.O. boxes)
  - Date of birth

Qualifying life event	Type of proof
☐ **1. Loss of health care coverage** Important: This is NOT a qualifying event if: • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and don't have any other coverage. • You voluntarily ended your coverage. • You had temporary or short-term coverage like traveler's insurance.	**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. ☐ Pay stubs of current and previous hours if you lost coverage because of a reduction in work hours. ☐ Proof of age and evidence of loss of coverage when a dependent child turns 26 and is no longer eligible to be covered under a parent's health plan. **Letter from your insurer or Medicaid or other government programs** ☐ Letter from your health insurance company showing a coverage end date, including a COBRA coverage end date. ☐ Letter from your student health plan indicating when student health coverage ended or will end. ☐ Letter or notice from Medicaid or the Children's Health Insurance Program (CHIP) stating when Medicaid 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.

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STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life 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 a 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.
☐ **2. Gaining or becoming a dependent through marriage or domestic partnership** **Check 2 boxes total** You have to submit proof of prior coverage for one spouse for at least one full day unless you were living in an area where no qualified health plan was offered through your Marketplace. Your state's Marketplace can tell you if no qualified health plan was available. You may send a screenshot from the Marketplace website or other documentation the Marketplace provides.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your old insurer (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ 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. ☐ Official government record, including date of domestic partnership registration.
☐ **3. Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care**	**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.

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Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
3. Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care *(continued)*	**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. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ Medical support court order. It must have a filing date stamp. ☐ Foster care papers dated and signed by a court official.
☐ **4. Child support order or other court order to cover a child**	☐ Signed court order with court filing date stamp.
☐ **5. Permanent relocation** Choose Permanent Relocation, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan.* *You have to submit proof of prior coverage for all applicants from your old insurer for at least one full day unless you were living in an area where no qualified health plan was offered through your Marketplace. Your state's Marketplace can tell you if no qualified health plan was available. You may send a screenshot from the Marketplace website or other documentation the Marketplace provides.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your old insurer for at least one full day in the last 60 days (applicants moving within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide any of these – one with your old residential address and one 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 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).

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Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **6. Change in eligibility for federal financial assistance through Washington Healthplanfinder**	☐ Most recent eligibility determination from Washington Healthplanfinder showing determination date.
☐ **7. Change in eligibility for employer health coverage** You're now eligible for a premium tax credit because your coverage through your employer has changed.	☐ 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.
☐ **8. Determination by Washington Healthplanfinder**	☐ Letter or notice from Washington Healthplanfinder stating you're eligible for a special enrollment period and showing determination date.

By submitting a signed application or Account Change Form and proof of your qualifying life event, you're saying that the qualifying life event happened. It's important that we get proof of your qualifying life event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we determine that the qualifying life event didn't happen, or we learn of any other inaccuracy in the information that is included in the application, Account Change Form or any other information that you submit, we may take legal action. The legal action may include, but is not limited to, canceling your coverage retroactively to the day it started. You may also be responsible for the full charges of any services that you received.

Submitting your proof

How are you applying?

- **If you're applying online:** Sign in at **kaiserpermanente.inshealth.com** and upload your proof. You don't need to upload this form.
- **If you're applying by mail or fax:** Use the information on this page to send your proof and this form to the address or fax number for your area.

Please note: Only use this form if you're applying for coverage directly from Kaiser Permanente, or if you applied for coverage directly from Kaiser Permanente and are making a change.

Send application or Account Change Form and proof along with this form:

By mail

Kaiser Permanente for Individuals and Families
RCB-C1W-02
P.O. Box 35002
Seattle, WA 98124-3402

By fax

Washington 206-877-0655

To get an Application for Health Coverage (application) or an Account Change Form call 1-800-358-8815 (TTY 711).

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington, 601 Union St., Suite 3100, Seattle, WA 98101.

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Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ **(Khmer)**៖ របយ័ត៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូ រស័ព

1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

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。 1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (1-800-833-6388 / 711) .

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.