



KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20849

BENEFIT PLAN SELECTION FORM

When to use this form: This form is to be completed if you are an existing Kaiser Permanente member and you wish to change your current benefit plan or you are a new member and you are selecting your benefit plan for the first time. **If you are an existing member and wish to remain in your current benefit plan, you DO NOT need to complete this form.**

Please print all information

Effective Date ____/____/____
Month Day Year

Subscriber Name (Last, First, MI): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: () _____ Home Phone: () _____

Social Security Number: ____ ____/____ ____/____ ____

Kaiser Permanente Medical Record Number
(Complete if you are an existing member) _____

Please choose **ONE** of the following benefit plans by checking the applicable box and signing this form. If you have family coverage, all family members will be enrolled in your selection.

- \$10/\$20 Copay Plan
- \$20/\$30 Copay Plan
- \$30/\$40 Copay Plan A
- \$30/\$40 Copay Plan B

Subscriber's Signature

Date

Please make a copy for your records

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

Enclose with payment, detach, and mail by (date) in the enclosed envelope

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Benefit Plan Selection Form