

KAISER PERMANENTE MEMBERSHIP APPLICATION FORM FOR INDIVIDUALS AND FAMILIES PLAN



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20852

Eligibility requirements

- All applicants requesting coverage must reside within the Kaiser Foundation Health Plan of the Mid-Atlantic States service area (see list of eligible ZIP codes in enrollment book or at kp.org).
- All applicants requesting coverage must pass medical underwriting requirements.

How to apply for coverage

Please answer all questions completely. If you or your family member who is applying for coverage responds “Yes” to any medical question, please explain the response in “Section V: Medical Questions Detail Description.”

If you are currently a dependent under an Individual membership plan who has (a) reached the limiting age under your parent’s plan, or (b) has experienced a qualifying event (e.g., divorce, death of subscriber) and wish to become the Subscriber, please complete Sections I, II, VI, and VII.

If you are currently a dependent who has reached the limiting age under your parent’s Federal or Employer group plan, please complete all sections of this application.

Use only blue or black ink. Please print clearly within the lines provided.

Remember to include the first month’s PREMIUM.

How to add dependents to an existing contract

If you are requesting to add a newly eligible dependent child or grandchild within 31 days of his/her first becoming eligible, because Section I of your Kaiser Permanente for Individuals and Families Membership Agreement, under the Enrollment and Effective Date of Coverage provision, permits the child’s or grandchild’s enrollment, you only need to complete Sections I and VI and to pay in full any additional premium. The child or grandchild will be enrolled without medical underwriting so long as we determine that the child or grandchild is eligible.

If you are requesting to add a dependent under any other circumstance, please complete Sections I, IV, V, and VI and include any additional premium. Please attach marriage or birth certificate, or domestic partner affidavit (certificate of domestic partnership if the partnership is registered in the District of Columbia), if applicable.

Effective dates

Upon approval, completed applications received by the fifteenth (15th) of the month will be effective the first (1st) of the following month. Applications received after the fifteenth (15th) of the month will be effective the sixteenth (16th) of the following month. Please note that the effective dates must be within 60 days of the date you sign and submit this application.

Please do not cancel any health coverage you may already have until notified in writing by Kaiser Permanente of approval of your application.

Any missing information will delay the process.

Mail completed application and first month’s premium to:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
KPIF Unit, 5E
2101 East Jefferson Street
Rockville, MD 20852
Tel: 301-816-6767

For the most recent list of available physicians, visit www.kp.org.

Section II: Payment Options

FINANCIALLY RESPONSIBLE PARTY

Name: Last First Middle Social Security Number

INITIAL PAYMENT INFORMATION

Make sure to include the first month's premium with your application. If we do not receive your first month's premium, your application cannot be processed and will be returned to you. **If you are adding dependents and the change causes your premium to increase, the difference between your current plan premium and the new rate is required with the application before the change can be processed.**

Method of Payment: There are three methods to make your first month's payment. Please check your method of payment.

Credit Card – can be used for mailed or online submission of application (if applying online you MUST use this method). The credit card will only be charged for your, or your family's, first month's premium and will only be charged upon approval of membership.

Please debit for Initial Payment: VISA MasterCard American Express Discover

Please Print: Name of account holder _____
Last First Middle

Credit Card Account No.: _____ Expiration Date: _____

Check – can be used only if mailing application.

Money Order – can be used only if mailing application.

FUTURE PAYMENT INFORMATION

Automated Draft Plan

I hereby authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente), to initiate debit entries for my monthly premium amount from my checking, savings, or credit card account as indicated on this form. This authorization is to remain in full force and effect until Kaiser Permanente has received written notification from me of its termination in such time and in such manner as to enable Kaiser Permanente reasonable opportunity to act. If an entry made by Kaiser Permanente to my account results in an overcharge, I have the right to have the amount charged in error credited to my account by Kaiser Permanente. Within thirty (30) calendar days following the date on which the financial institution sent or made available to me a statement of account or notification pertaining to the erroneous entry, I must mail or fax to Kaiser Permanente a written notice identifying the entry, stating that the entry was in error, and requesting that Kaiser Permanente credit my account or issue a refund check for the amount charged in error.

Please continue to make payments by invoice until you receive written notice from Kaiser Permanente of the date when your first month's automated deduction will become effective.

Banking Information:

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account and agreeing to the terms outlined above under Automated Draft Plan.

Please Print: Name of account holder _____
Last First Middle

• Please debit my checking account #: _____ / account routing #: _____

• Please debit my savings account #: _____ / account routing #: _____

Credit Card Information:

By filling out this section, you are requesting that your premiums be automatically deducted from your credit card and agreeing to the terms outlined above under Automated Draft Plan.

Please debit for Initial Payment: VISA MasterCard American Express Discover Same card used above

Please Print: Name of account holder _____
Last First Middle

Credit Card Account No.: _____ Expiration Date: _____

If you do not choose a payment method, you will automatically receive a **monthly invoice** from Kaiser Permanente. You are still required to send your first month's premium with this application. Payment is due on or before the first day of each month. If payment is not received by this date, you are subject to termination of your membership.

What if one or more family members is denied coverage?

Please remember Kaiser Permanente for Individuals and Families Plans are individually underwritten. Each family member must pass medical review. It is possible that some or all of the family members may not be accepted into the plan that you or your family members have selected. In the event that not all family members are accepted, please instruct us how to handle accepted family members. All subscribers must be 18 or over. To obtain family coverage, at least one of the accepted members must be a parent. Please check one box:

Enroll all accepted family members

Cancel the enrollment process for all accepted family members and return my first month's check (if applicable)



Section III: HIPAA Eligibility Questionnaire and Request for Enrollment

Notice to Maryland applicants:

You are not eligible for coverage under our HIPAA product, however you may be eligible for health care coverage under the Maryland Health Insurance Plan (MHIP). MHIP is a high-risk pool for Maryland residents who are medically uninsurable. You may obtain more information regarding MHIP from the Maryland Health Insurance Plan, 10455, Mill Run Circle, Mail Stop RR-291, Owings Mills, MD 21117-9685, Ph: 1-888-444-9016 (toll free). Information regarding MHIP also may be obtained from the MHIP Web site at www.marylandhealthinsuranceplan.state.md.us.

Notice to District of Columbia and the Commonwealth of Virginia applicants:

You may be eligible for individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet all of the five requirements listed below. Please complete this page so that your eligibility for individual coverage under HIPAA can be determined. This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families Plan coverage but meet ALL of the following five requirements, you are guaranteed coverage in a Kaiser Permanente HIPAA-qualified plan with benefits most like the Kaiser Permanente for Individuals and Families Plan to which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA-qualified plan.

Note: We will guarantee to enroll you in the applicable Kaiser Permanente HIPAA-qualified plan only if you meet HIPAA eligibility requirements, and only if your Kaiser Permanente for Individuals and Families Plan application is declined. If you qualify for both plans, we will enroll you in Kaiser Permanente for Individuals and Families Plan. Both plans have the same benefits, but HIPAA rates are significantly higher than Kaiser Permanente Individual and Family Plans. Information on your specific HIPAA-qualified plan rate is available by calling 301-816-6767.

If you are a District of Columbia or Commonwealth of Virginia resident and do not answer all of the questions below and/or fail to sign the form attesting to your desire to enroll in our HIPAA product, we will not consider your application for enrollment in our HIPAA product.

Questionnaire for District of Columbia and Commonwealth of Virginia applicants

Please read the following five statements and then answer the three questions below.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
2. My most recent health care coverage was through a group health plan, a governmental plan or a church plan.
For Virginia residents: My most recent health care coverage was through: (a) a group health plan; (b) a governmental plan; (c) a church plan; or (d) an individual policy or contract that was discontinued by a carrier that ceased offering all individual health coverage in Virginia.
3. I have both elected and exhausted all continuation of health care coverage available under Federal (COBRA) and state continuation of coverage laws.
4. I do not currently have other health care coverage and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. **My most recent coverage was NOT terminated for fraud or failure to pay premiums.**

Please answer the following three questions:

- I. I have read the above five statements and attest that each of them is completely true.
If I answer "No", I understand that I do not qualify for HIPAA. No Yes
- II. If I do not qualify for Kaiser Permanente for Individuals and Families Plan and I do qualify for HIPAA, I request that I be enrolled in a Kaiser Permanente HIPAA-qualified plan. No Yes
- III. If you answered "Yes" to the question above, please attach certificate(s) of creditable coverage. Your enrollment in a HIPAA-qualified plan may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership. I have attached proof(s) of creditable coverage. No Yes

Applicant (Please Print)

Applicant Signature

Date



Section IV: Medical History

Applicant: Height ___' ___" Weight: _____ lbs.

Spouse/Partner*: Height ___' ___" Weight: _____ lbs.

For each of the following, please check either **No** or **Yes**. If you check yes for any question, please provide an explanation in Section V: Medical Questions Detail Description.

1. Are you or any dependent **currently** under any treatment or prescribed medication?..... No Yes
2. Have you or any dependent gained/lost more than 20 lbs or experienced unexplained fatigue in the past **12** months?..... No Yes
3. Have you or any dependent ever been diagnosed with, counseled, consulted, treated for, or had any known symptoms for any of the following within the last **5** years:
 - a. Disease of the heart, arteries or blood vessels; chest pain; high or low blood pressure (if yes for high blood pressure please provide last 3 blood pressure readings in Section V)?..... No Yes
 - b. Nervous system, brain, mental or emotional disorder; convulsions; epilepsy; unconsciousness; chronic or recurrent headaches; stroke?..... No Yes
 - c. Oral cavity, eye, ear, nose or throat disease or disorder including TMJ?..... No Yes
 - d. Asthma or other disease of lungs or respiratory organs/systems?..... No Yes
 - e. Kidney stones; disease of the kidney, or bladder; male or female reproductive organ dysfunction, disorder, or disease? No Yes
 - f. Cysts, tumors, neoplasms, cancer or abnormal growths; leukemia or any other cancer or malignancy? (state type; part of the body)..... No Yes
 - g. Diabetes; disease/disorder of the thyroid or other glands; or enlargement of the lymph nodes?..... No Yes
 - h. Liver, stomach, pancreas, gall bladder, intestinal or colon disease/disorders; rectal bleeding?..... No Yes
 - i. Arthritis, bone/joint, skin, muscle or connective tissue disorder; spine disorder; back pain/disorder? No Yes
 - j. Paralysis, or any other physical impairment or deformity? No Yes
 - k. Alcoholism or drug habit/abuse or been advised to reduce alcohol intake by a medical professional? No Yes
 - l. Anemia, sickle cell disease or other diseases/disorders of the blood? No Yes
4. Have you or any dependent been diagnosed with or received treatment for AIDS or a HIV positive status or other recurrent immune system disorder within the past **5** years?..... No Yes
5. Have you or any dependent been hospitalized or had hospitalization advised, or had surgery or been advised to have surgery? No Yes
6. For female applicants over age **11** only
 - a. Are you pre-menstrual (have never menstruated), post-menopausal, or have you had a hysterectomy or tubal ligation? If yes, please document which in Section V. No Yes
 - b. If no, please provide date of last menstrual cycle (___/___/___).
7. Are you or any dependent pregnant or have you or any dependent experienced any medical complications of pregnancy? No Yes
8. Have you or any dependent:
 - a. tried and have been unable to become pregnant in the last **5** years? No Yes and/or
 - b. been seen, examined, tested, diagnosed or treated by a licensed practitioner for infertility during the past **5** years? No Yes
9. Have you or any dependent been disabled or received Workers' Compensation benefits within the last **5** years?..... No Yes
10. Within the last **5** years have you or any dependent been denied coverage by Kaiser Permanente or any other health, accident, or life insurance company?..... No Yes
11. Have you or any dependent ever smoked? If yes, please list how long and how many packs/day in Section V. No Yes
12. Have you or any dependent had any injury, illness, medical attention or medical advice or treatment during the last **5** years for any reason not already mentioned?..... No Yes



Section VI: Terms and Conditions

ALL APPLICANTS, PLEASE READ THE FOLLOWING INFORMATION AND SIGN IN THE SPACE NOTED BELOW

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a customer service representative at 301-816-6767 before signing this application.

I hereby apply for a Kaiser Permanente for Individuals and Families Plan, written by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereafter "Health Plan"). **I certify that the representations made herein are true and accurate to the best of my knowledge and belief. I understand that Health Plan will rely on the representations made herein when making its decision to issue coverage.**

I agree to advise Health Plan immediately in writing of any change in my or my dependent's health status that occurs prior to the effective date of coverage and that any such change in condition may require reconsideration of my application. Updates should be sent to: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, MD 20852, Attention: KPIF Unit Health Status Update, or by fax to 301-388-1735.

I agree that if I (a) fail to fully and accurately disclose my health history, or that of my dependents; (b) make a material misrepresentation in my application; or (c) fail to inform Health Plan in writing of any changes in my or my dependents health status, then Health Plan may deny or rescind coverage for myself and all my dependents. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.

This document, together with any supplements, shall be part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

MD RESIDENTS:

WARNING: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DC AND VA RESIDENTS:

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

IMPORTANT: All applications must be signed and dated by the applicant, spouse/partner (if applicable), and any dependent children over 18 years of age (if applicable). The answers provided in this application are representations and not warranties. I hereby certify that I have read and understand all of the above terms and conditions and that the answers I have provided in this application are true and complete to the best of my knowledge and belief.

_____ Signature of Applicant	_____ Date	_____ Signature of Spouse/Partner*	_____ Date
_____ Signature of Dependent 18 years of age or older	_____ Date	_____ Signature of Dependent 18 years of age or older	_____ Date
_____ Signature of Dependent 18 years of age or older	_____ Date	_____ Signature of Dependent 18 years of age or older	_____ Date
_____ Signature of Dependent 18 years of age or older	_____ Date	_____ Signature of Dependent 18 years of age or older	_____ Date

Note: Applications must be signed and received no more than 60 days prior to the requested effective date.

* Partner means a Domestic Partner, and, with respect to District of Columbia applicants only, it also includes a Legal Partner (any same-sex relationship recognized as valid by any other jurisdiction, such as civil unions). This definition of Partner applies whenever this term is used in this application.



Section VII: Authorization

I authorize any physician or health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional, insurer or health maintenance organization to give Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., or its affiliates ("Kaiser Permanente"), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental health or emotional disorders, sexually transmitted diseases, HIV, AIDS (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS Related Complex), of me or any of my dependents applying for or having membership in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. products. I understand that this information may be collected in connection with the review, investigation or evaluation of an enrollment form or of any claim for benefits.

Kaiser Permanente may disclose medical or personal information related to myself or any covered dependent as permitted or required by federal and state law. Under certain circumstances, protected health information disclosed to others may no longer be protected by Kaiser Permanente policies or the HIPAA Privacy Rule, and may be redisclosed by the recipient in accordance with federal and state law. See Notice of Privacy Practices.

For contracts issued in the Commonwealth of Virginia or District of Columbia: I understand that this authorization shall be valid: a) for thirty (30) months from the date the authorization is signed if it is for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits; or b) for the term of coverage if this authorization is signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy. Except as stated above, I understand that this authorization will automatically expire 12 months from the date signed. I may revoke this authorization at any time prior to its expiration except to the extent that action has already been taken in reliance on it. See Notice of Privacy Practices for instructions on revoking authorizations.

A photocopy of this authorization is as valid as the original, and I, or any person authorized to act on my behalf (including Kaiser Permanente agent or broker) may receive a copy of this form. A recipient of this authorization also may be provided a copy. I understand that I am entitled to inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request prior to duplication.

Signature of Applicant	Date	Signature of Spouse/Partner*	Date
Signature of Dependent 12 years of age or older	Date	Signature of Dependent 12 years of age or older	Date
Signature of Dependent 12 years of age or older	Date	Signature of Dependent 12 years of age or older	Date
Signature of Dependent 12 years of age or older	Date	Signature of Dependent 12 years of age or older	Date

Please Note: Applications must be signed and received no more than 60 days prior to the requested effective date.

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