


KAISER PERMANENTE®
 Kaiser Foundation Health Plan of the Northwest
 Individuals and Families

I Instructions

- Please use ink to complete and sign this application.
- Make sure this application is **complete** and **signed**. If your application is incomplete, it may delay your effective date. Parents or legal guardians must sign for children under the age of 18. Applicants who are 15 years of age and older must sign the "Authorization to Obtain or Release Medical Information." We are unable to process applications without appropriate signatures.
- If you have general questions regarding Individuals and Families or questions regarding this application form, please call **1-800-914-5521**. To be eligible for this plan, you must live in our Southwest Washington service area.
- **If you make an intentional misrepresentation of material fact, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may deny your application for coverage, modify your coverage, or cancel or rescind your coverage contract, and/or take any other legal action available to it by law. Making an intentional misrepresentation of material fact means to intentionally provide incorrect information, or to intentionally omit information, about the health history or status of any person applying for coverage, and we rely upon such misrepresentations when deciding to accept an applicant for coverage. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**
- If you are eligible for Medicare, please call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

EXPEDITE YOUR APPLICATION – APPLY ONLINE NOW AT BUYKP.ORG/APPLY.

II Enrollment information

Complete the following information **and** submit one application for **each** family member **applying**:

Applicant	Last name	First name	Middle initial	Previous name(s)	
Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Social Security number	Health record number (if any)
Residence (street address)					
City			State	ZIP	
Home phone		Work phone		County	

Billing address (complete only if billing should be sent to an address other than listed above)	
Name C/O	Relationship to Applicant
Address/P.O. Box	City, State, ZIP

Names of other family members submitting applications. (This helps us to process family members together.)

Spouse/ Domestic partner*	Last name	First name	Middle initial	Date of birth	Previous name(s)
Child					
Child					
Child					

*A *domestic partner* is a person registered and legally recognized as your domestic partner by Washington or another state.

For official use only

Date received	<input type="checkbox"/> New account	<input type="checkbox"/> Reapplication	Effective date _____
	<input type="checkbox"/> Conversion	<input type="checkbox"/> Upgrade	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
	<input type="checkbox"/> Add-on		

III Plan selection

Choose one Individuals and Families deductible plan:

Gold Plan

KP 1000/25/Rx

Silver Plans

- KP 1500/30/Rx
- KP 2500/30/Rx
- KP 3500/30/Rx
- KP 5000/30/Rx
- KP 7500/30/Rx

Bronze Plans

- KP 2500/35/NM
- KP 3500/35/NM
- KP 5000/35/NM
- KP 7500/35/NM

Dental plan options:

- Plan 1
- Plan 2
- Plan 3

Please note: To enroll in the optional dental plan, you must also be enrolled in an Individuals and Families medical plan.

Additional information about these plans is available upon request.

Tobacco use information

The smoker rate will apply if the Applicant has used tobacco products within the 12 months prior to this application.

Have you used tobacco products in any form during the past 12 months? Yes No

I am adding a new person to a current Individuals and Families account with family coverage. If accepted, your family member will be added to your current plan.

Health record number of your current account: _____

If approved, I would like to be enrolled with an effective date of:

- 15th of the current month (Your application must be received by the 8th of the current month.)
- 1st of the next month (Your application must be received by the 23rd of the current month.)
- 15th of the next month (Your application must be received by the 8th of the next month.)
- 1st of the month after the next (Your application must be received by the 23rd of the next month.)

Note: Premiums for enrollments beginning on the 15th of the month will be prorated for that month only, after which the standard billing cycle (1st of the month) will apply.

IV Prior or current coverage

This coverage has a nine-month waiting period for pre-existing conditions. This means that we do not pay for expenses incurred by Applicants age 19 and older for pre-existing conditions during the nine months following the effective date of coverage. A pre-existing condition is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

The pre-existing condition exclusion is waived (1) if you are currently a member and adding a newborn or new adoptee, (2) if you are applying for new coverage and had prior insurance coverage, and/or (3) if Applicants are ages 0 through 18.

If you are not a HIPAA-eligible individual and had or have had group or individual coverage within 63 days of the date of this application, that coverage may reduce the nine-month pre-existing condition exclusion. Please read the section below describing the conditions you must satisfy in order for your prior coverage to reduce the pre-existing condition exclusion, and check the appropriate box.

Pre-existing condition waiting period waiver

- I am a HIPAA-eligible individual.** If you are applying for individual coverage, we will waive the nine-month pre-existing condition waiting period if you qualify as HIPAA-eligible.

Crediting prior coverage to reduce the pre-existing condition exclusion

- I have or have had group or individual coverage within 63 days of the application date.** Under certain circumstances, we will reduce the duration of the pre-existing condition exclusion by the coverage you had within 63 days of the date you applied for coverage. Prior creditable coverage is determined separately for each enrollee.

If crediting prior coverage to reduce the pre-existing condition exclusion applies to you, fill in the appropriate blanks at the end of this section and provide appropriate documentation. If necessary, we may request a copy of your certificate of creditable coverage.

The following information can be used to prove prior coverage:

1. Pay stubs that reflect a premium deduction
2. Explanation of benefits forms
3. A benefit termination notice from Medicare or Medicaid
4. Verification by a doctor or your former health care benefits provider that you had prior health coverage
5. Certificate of creditable coverage

Details regarding current or prior coverage

1. Name of insurance company _____
Phone (_____) _____
2. Date coverage began _____
Date coverage ended _____
3. Type of coverage:
 - Group plan
 - Church plan
 - Individual plan
 - Washington Basic Health Plan (BHP)
 - WSHIP
 - Healthy options plan
 - Federal plan
(e.g., TRICARE, FEBHP, or Peace Corps Act)
 - Plan established/maintained by a foreign country or any political subdivision thereof
 - PEBB or Uniform Medical Plan
 - Plan of Indian Health Service or tribal organization
 - College, school, or short-term insurance
4. Deductible amount per year:
Individual _____
Family _____
5. Coinsurance _____
6. Coverage does or did include:
 - Maternity
 - Hospital only
 - Prescription drugs
 - Waiting periods for organ transplants
 - None of the above
7. Name of Applicant covered by current or prior insurer

8. Are you currently on or did you recently exhaust, terminate, or decline COBRA or state continuation coverage?
 - Yes
 - No
 If Yes, date coverage began _____
Date coverage ended _____
9. Are you eligible for the following?
 - Medicare Part A or B Yes No
 - Medicaid Yes No

If you answered Yes to Medicare, do not continue. Call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

If you answered Yes to Medicaid, do not continue. Call **1-800-562-3022** (TTY 1-800-735-2900), 8 a.m. to 5 p.m., Monday through Friday, for further information and assistance.

V Standard Health Questionnaire requirements

A separate *Standard Health Questionnaire for Washington State* must be submitted for each individual applying for coverage (see the *Standard Health Questionnaire* for specific guidelines).

If you can answer **Yes** to any of the following questions, please mark the appropriate box next to the question that applies to you. If you can mark any of the boxes below as **Yes**, you are considered exempt and you do **not** need to complete the *Standard Health Questionnaire*. Instead, you may apply to Kaiser Foundation Health Plan of the Northwest, without the *Standard Health Questionnaire*, by submitting a copy of this application along with the appropriate documentation listed for each question you marked **Yes** below. If you cannot mark any of the boxes below as **Yes**, you **must** complete the *Standard Health Questionnaire*.

If you are exempt from completing the *Standard Health Questionnaire* for any of the reasons described below, please mail the indicated supporting documentation along with the completed application to Individuals and Families, P.O. Box 7104, Pasadena, CA 91109.

Yes	
<input type="checkbox"/>	<p>1 Have you changed residences from one part of Washington State to another part where your current health plan is not offered, and you are submitting your application within 90 days of relocation?</p> <p><i>Please include a copy of a utility bill in your name from your prior address and a letter of verification from your prior carrier.</i></p>
<input type="checkbox"/>	<p>2 Is your health care provider no longer part of the provider network on your current individual health plan?</p> <p>To answer Yes, <i>all</i> of the following must be true:</p> <p>a. Your health care provider is on the new health plan you are applying for; <i>and</i></p> <p>b. You received services from that provider during the 12 months before he or she left your current health plan; <i>and</i></p> <p>c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network.</p> <p><i>Please include a letter from your current health care provider or a certificate of creditable coverage.</i></p>
<input type="checkbox"/>	<p>3 Are you applying for individual health coverage within 90 days of using up your COBRA* coverage?</p> <p>(This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.)</p> <p>To answer Yes, you must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium.</p> <p><i>Please include a certificate of creditable coverage or a letter from your employer noting beginning/ending dates of COBRA plan.</i></p>
<input type="checkbox"/>	<p>4 Have you been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event?</p> <p><i>Please include a certificate of creditable coverage and a letter from your employer noting beginning/ending dates of coverage, number of employees, and persons covered on the plan.</i></p>

V Standard Health Questionnaire requirements (continued)

Yes	
<input type="checkbox"/> 5	<p>Are you applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination? (Not applicable to BHP applicants.)</p> <p><i>Please include a certificate of creditable coverage and a letter from your employer noting beginning/ending dates of COBRA coverage.</i></p>
<input type="checkbox"/> 6	<p>Are you applying for individual health coverage within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event but you choose not to take COBRA coverage? (Not applicable to BHP applicants.)</p> <p><i>Please include a certificate of creditable coverage and a letter from your employer noting the date of the event.</i></p>
<input type="checkbox"/> 7	<p>Have you been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment?</p> <p><i>Please include a certificate of creditable coverage.</i></p>
<input type="checkbox"/> 8	<p>Are you adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days?</p> <p><i>Include a copy of the birth certificate, adoption placement paper, or confirmation letter of legal obligation.</i></p>
<input type="checkbox"/> 9	<p>Are you applying for individual insurance 90 days before or after your employer discontinues your group insurance due to business closure and you had at least 24 months of continuous group insurance coverage immediately prior to your insurance being discontinued and the effective date of the individual insurance you are applying for is on or within 90 days after the date your group insurance is discontinued?</p> <p><i>Please include a certificate of creditable coverage and a letter from your employer noting the date of the business closure.</i></p>

* COBRA refers to the federal law that requires certain employers to continue health coverage temporarily for certain former employees, retirees, spouses, and dependents at their expense when coverage is lost due to certain specific events. For more information about COBRA rules, go to the U.S. Dept. of Labor website: dol.gov/ebsa/faqs.

VI Standard Health Questionnaire instructions

General description

The health questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is for people who are unable to obtain individual medical coverage with insurance carriers.

By completing this form, you will be giving your medical information to Kaiser Foundation Health Plan of the Northwest (KFHPNW). Your answers will determine if KFHPNW will accept your application or if you will be referred to WSHIP.

This health questionnaire is not for people who have Medicare benefits.

When evaluating your application, KFHPNW will use the following medical information:

- Information provided on the health questionnaire.
- Any medical information on file from prior membership with KFHPNW (if applicable).

Your health questionnaire answers will be scored using a standard scoring system designed by WSHIP. KFHPNW does not have control over the questions or the scoring system.

Instructions

1. This application, including the health questionnaire, must be filled out completely and submitted to Individuals and Families, P.O. Box 7104, Pasadena, CA 91109.
2. This health questionnaire must be completed in full and will be valid for a 90-day period. If you wait more than 90 days to submit your application, you will have to complete a new health questionnaire.
3. Do not send medical records with this questionnaire. KFHPNW does not require medical records to process your application.
4. Make sure that you **sign and date** this application and mail it to KFHPNW along with any other required materials.
5. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
6. If you have questions about this form, contact your producer or call KFHPNW at **1-800-914-5521**.

If you are rejected for coverage and request an appeal, KFHPNW may then request further information. You may choose to supply this added information if you believe it will be of assistance in scoring your questionnaire correctly.

A copy of the scoring system document is available by calling the WSHIP administrator at **1-800-877-5187**. Documents may be viewed and printed by going to the WSHIP website at wship.org. **Questions about the scoring of your questionnaire should be directed to KFHPNW or your insurance producer, but not to the WSHIP administrator.**

KFHPNW may not reject your application unless we mail a notice of rejection within 15 business days after we have received your completed submission. **To be complete, this health questionnaire must be signed and dated with no missing information that might affect your score, and the application must be completed in its entirety.**

Note: If you answered Yes to an exemption question on page 2 of the *Standard Health Questionnaire*, you are exempt from completing the full medical questionnaire. **However, in order for your application to be considered complete, you must mail a copy of your completed application to Individuals and Families, P.O. Box 7104, Pasadena, CA 91109. Other supporting documentation may be required later.**

VII Billing information

Application must be accompanied by payment information for your initial premium. Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

Mr. Mrs. Ms. Miss

Last name

First name MI

Billing address Apt./Unit #

City State ZIP

2. Credit/Debit card information: Credit Debit

Visa Discover
 MasterCard American Express

Name as it appears on card

Credit/Debit card number

Expiration date

After your initial payment is received, we will not retain the billing information on the reverse side of this page in our records and we will destroy this page.

VIII Certification/Authorization**Certification of completion and correctness**

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form.

I understand that if I make an intentional misrepresentation of material fact, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may deny my application for coverage, modify my coverage, or cancel or rescind my coverage contract, and/or take any other legal action available to it by law. I understand that making an intentional misrepresentation of material fact means to intentionally provide incorrect information, or to intentionally omit information, about the health history or status of any person applying for coverage, and KFHPNW relies upon such misrepresentations when deciding to accept an applicant for coverage. I must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect.

In the event KFHPNW decides to rescind your coverage, we will send you a written notice at least 30 days before we actually rescind, explaining the basis for our decision and how you can appeal it. Once coverage is rescinded, you will be required to pay for any Services we may have covered, but you would also be entitled to a refund of any Premiums paid. This means that Premium refunded would be reduced by any amounts you owe for any covered Services you received.

I understand and agree that no coverage shall be in force until approved by KFHPNW. If approved, coverage will be in force as of the effective date determined by KFHPNW. KFHPNW may phone me to clarify answers on this application. As the Applicant, I understand I have the right to inspect the information in my file.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X

Applicant's signature

If you are signing on behalf of an underage child, check: Parent Legal guardian

Producer authorization**(if you are working with a health insurance producer)**

I (the Applicant) authorize the insurance producer listed below to share enrollment, disenrollment, and summary plan information specific to this application with KFHPNW. I understand that the producer of record may receive monetary and/or nonmonetary payments from KFHPNW in connection with the purchase of this health plan coverage.

X

Applicant's signature

I (the producer) have not made any representations to the Applicant about any provisions, benefits, conditions, or limitations of the health plan agreement except through written materials furnished by KFHPNW. The Applicant has been informed that the effective date of coverage is assigned by KFHPNW. I certify that the information supplied to me by the Applicant has been truly and accurately recorded.

Gordon Paul	91191	888-492-7245	gpaul@kaiserinsuranceonline.com
Producer's name	Number	Phone	E-mail address
Gordon Paul	888-492-7245	888-459-6546	
Agency name	Number	Fax	
Street address	City	State	ZIP

X

Producer's signature

Today's date

IX Individuals and Families Authorization**Authorization to Obtain or Release Medical Information**

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional who has provided any services to an *Applicant* (defined as me or any of my family members applying for or having membership in any Kaiser Foundation Health Plan product) to give Kaiser Foundation Health Plan of the Northwest (KFHPNW) or its affiliates, its respective agents, employees, designees, or representatives, including my insurance producer, any Applicant's *Medical Information* (defined as **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 or emotional disorders, sexually transmitted diseases, HIV [human immunodeficiency virus] status, or AIDS [acquired immune deficiency syndrome]**). However, Medical Information does not include genetic information or *psychotherapy notes* (as defined by 45 C.F.R. § 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize KFHPNW to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize KFHPNW to disclose to my insurance producer the status of my application for coverage, as well as that of any family member on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected (except for any Applicant under the age of 19 who must be accepted under applicable law); if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the coverage.

I will sign new authorizations, if necessary, so that in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits, KFHPNW may request, use, and disclose Medical Information, HIV/AIDS-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by KFHPNW in connection with the review, investigation, or evaluation of any claim for benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy of this authorization is as valid as the original, and I and my insurance producer are entitled to receive a copy of this form.

I may revoke this authorization (to the extent applicable to my Medical Information) at any time prior to its expiration. However, revocation is not effective to the extent that KFHPNW has already taken action in reliance on it, or for so long as KFHPNW may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations are in KFHPNW's *Notice of Privacy Practices*.

Signatures (required)**X**

Applicant/Parent or legal guardian (age 18 or over)

Today's date

Date of birth

X

Applicant (age 15 or over)

Today's date

Date of birth

Important: Applicants age 18 or over must sign and date above on the appropriate signature line. A parent or legal guardian must sign for Applicant under the age of 18. In addition, Applicants age 15 or over must sign and date above on the designated signature line. Use ink only.

**Please read and sign in all the places noted and photocopy for your records.
We will be unable to process your application without your signature.**