

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

____ SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: Please answer all questions and print or type **using ink only**. You should sign this application only if you understand each question and agree to the response provided—even if a broker assists you with the application. **If you have questions about completing this application (in English or another language), please call 1-800-632-9700. Or, if you are working with a broker, please call him or her for assistance.**

Kaiser Foundation Health Plan (KFHP) offers family coverage and rates if everyone selects the same benefit plan. If you want coverage for your family on the same KFHP plan, please complete one application for the family. If one family member wants a different benefit plan, he or she must complete a separate application.

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

Application for Coverage (head of household only)

Last name

First name

MI

Residential address for covered party:

Street address

Apt./Unit #

City

State

ZIP

() _____
Home phone

Day Evening

() _____
Work phone

Day Evening

E-mail address

E-mail address

How do you prefer to be contacted? E-mail U.S. mail

Primary spoken language:

English

Other (please specify) _____

Race:

White

Black

Native American

Asian/Pacific Islander

Other (please specify) _____

Decline to state

Ethnicity:

Latino

Non-Latino

Decline to state

To make sure our Kaiser Permanente for Individuals and Families plan is right for you, please take a few moments to consider these questions:

Yes No **Do you work for an employer who has from one to 50 employees who work 24 hours or more a week?**

If you answered No, you've picked the right health plan. If you answered Yes, please answer the following questions and read on.

Yes No **Will your employer receive a tax deduction for your health care coverage?**

Yes No **Will your employer pay for your coverage or reimburse you for any portion of your premium?**

Important: If you answered Yes to either of the last two questions, you are not eligible for Kaiser Permanente for Individuals and Families plan coverage. However, you may be eligible for small group health insurance coverage.

II Account Information

Please check all boxes that apply.

1. Are you adding a family member to an existing Kaiser Permanente for Individuals and Families (KPIF) account?

Yes No

2. Are you switching coverage/plan selection from an existing KPIF account?

Yes No

3. Are you applying for a new KPIF account?

Yes No

4. Which plan would you like to apply for?

(Select only one plan.)

- \$5,000 HSA-Qualified Deductible HMO Plan (100%)
- \$4,000 HSA-Qualified Deductible HMO Plan (100%)
- \$3,000 HSA-Qualified Deductible HMO Plan (100%)
- \$2,500 HSA-Qualified Deductible HMO Plan (100%)
- \$2,000 HSA-Qualified Deductible HMO Plan (100%)
- \$2,000 HSA-Qualified Deductible HMO Plan (80%)
- \$5,000 Deductible Plan (70%)
- \$5,000 Deductible Plan (60%) with Rx (Children's)
- \$3,000 Deductible Plan (70%) with Rx
- \$2,000 Deductible Plan (70%)
- \$2,000 Deductible Plan (70%) with Rx
- \$1,500 Deductible Plan (80%) with Rx
- \$1,000 Deductible Plan (80%) with Rx
- \$40 Copayment Plan with Rx
- \$35 Copayment Plan with Rx
- \$30 Copayment Plan

Note: All applications must be accompanied by payment information. Please make certain that you have provided the necessary information on page 17 of this application.

III Family Members to be Covered

If any family members have a different home address than the applicant, please list that address under their names. Attach additional pages if necessary.

Self:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number				

Spouse:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number		Home address (if different than applicant's)		

Child:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number			Home address (if different than applicant's)	
				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number			Home address (if different than applicant's)	
				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number			Home address (if different than applicant's)	
				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last name	First name	Previous name (if any)	Date of birth	M/F
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
Social Security number			Home address (if different than applicant's)	
				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No

(continues on page 4)

III Family Members to be Covered (continued)

For each individual listed on page 3, please give the name of the family member's current or most recent primary care physician, along with his or her address and telephone number. Please also give the name of each individual's current or most recent health care coverage provider. Attach additional pages if necessary.

Self:
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

Child: _____
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

Child: _____
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

Spouse:
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

Child: _____
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

Child: _____
Doctor _____
Phone _____
Date last visited _____
Address _____
City, State, ZIP _____
Provider _____ Current
or Date ended ____ / ____ / ____ **or** Not insured

IV Kaiser Permanente for Individuals and Families Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan member. Omissions or incomplete answers will delay processing of your application. **Intentional misrepresentation can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IX on page 19 for details).**

This application becomes part of your permanent record with Kaiser Permanente. If English is not your native or primary language, you may call Member Services toll free at **1-800-632-9700** or **303-338-3800** to request assistance completing this questionnaire. Kaiser Permanente does not discriminate based upon: race; color; national origin; ancestry; religion; sex (including gender, gender identity, or gender-related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth); marital status; sexual orientation; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Note: This is a family-level questionnaire. You must answer each question for yourself and for everyone you are applying for. Please answer Yes or No to each question. Each question that you answer Yes and each condition that you check Yes requires an explanation. Please see the chart on page 13 and provide the information requested.

Check the Yes or No box for each letter subquestion. Every line must be answered Yes or No. When you answer each question, answer not only for yourself but for everyone you are applying for.

1. **Within the last 12 months**, were you (or anyone you are applying for) hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?
 - Yes No

2. **Within the last 12 months**, have you (or anyone you are applying for) sought advice or treatment from a medical professional's office?
 - Yes No a) Physical exam
 - Yes No b) Minor illness or injury now resolved and without a recommendation of further treatment; for example, cold, allergic reaction, flu, sore throat, cut requiring stitches
 - Yes No c) Regular chiropractic visits
 - Yes No d) Prenatal care
 - Yes No e) Psychological counseling
 - Yes No f) Medication management
 - Yes No g) A reason not listed above

3. **Within the last 3 years**, have you (or anyone you are applying for) been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?
 - Yes No

4. **Within the last 3 years**, have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with **your (or his/her)** alcohol or substance abuse?
 - Yes No

(Medical questionnaire continues on page 6.)

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

5. **Within the last 3 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any skin/dermatological disorders?

- Yes No a) Acne
 Yes No b) Psoriasis
 Yes No c) Burns
 Yes No d) Keloids requiring plastic surgery
 Yes No e) Cosmetic or reconstructive surgeries, revisions
 Yes No f) A skin or dermatological condition not listed above

6. **Within the last 3 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any disorders of the eyes, ears, nose, or throat?

- Yes No a) Glaucoma
 Yes No b) Cataracts, cataract surgery for one or both eyes
 Yes No c) Crossed eyes
 Yes No d) Detached retina
 Yes No e) Macular degeneration
 Yes No f) Deviated septum
 Yes No g) Sleep apnea, chronic snoring, or unresolved insomnia
 Yes No h) Nasal and/or throat polyps
 Yes No i) A condition of the eyes, ears, nose, or throat not listed above

7. Have you (or anyone you are applying for) ever used tobacco, including snuff and chewing or other smokeless tobacco?

- Yes No

If Yes, please provide his or her name: _____

- Yes No a) Do not use currently, but used from age ____ to age ____
 Yes No b) If you smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:
 Cigarettes: ____ packs per day
 Pipes: ____ bowls per day
 Cigars: ____ per day

(If this question pertains to more than one person applying, please list additional name[s] and answers on page 13, using the format above.)

8. **Within the last 5 years**, have you (or anyone you are applying for) taken or used illegal drugs or prescription drugs not prescribed by a medical professional for yourself (or anyone you are applying for)?

- Yes No

9. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any brain, neurological, or nervous disorder?

- Yes No a) Multiple sclerosis
 Yes No b) Autism
 Yes No c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
 Yes No d) Seizures treated with more than 2 medications for control
 Yes No e) Seizures under control with 2 or fewer medications
 Yes No f) Most recent seizure within the last 12 months
 Yes No g) Alzheimer's disease
 Yes No h) A brain, neurological, or nervous disorder not listed above

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

10. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any heart or cardiovascular disorders?

- Yes No a) Aneurysm
- Yes No b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment
- Yes No c) Chest pain
- Yes No d) Heart attack or angina
- Yes No e) Congestive heart failure
- Yes No f) Angioplasty or coronary artery bypass
- Yes No g) Pacemaker
- Yes No h) Tachycardia or other heart arrhythmia
- Yes No i) Other heart disease or valve disease
- Yes No j) Current medication(s) to control heart disease or cardiovascular symptoms
- Yes No k) A heart or cardiovascular condition not listed above

11. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any respiratory disorders?

- Yes No a) Chronic asthma treated with medications for control
- Yes No b) Asthma treated with prednisone therapy
- Yes No c) Asthma treated only with occasional use of inhalers
- Yes No d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months
- Yes No e) Emphysema
- Yes No f) Chronic bronchitis
- Yes No g) Chronic obstructive pulmonary disease
- Yes No h) Cystic fibrosis
- Yes No i) Pulmonary tuberculosis, active or arrested
- Yes No j) A lung or respiratory disorder not listed above

12. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any muscle or bone disorders?

- Yes No a) Back or neck pain or injury currently under treatment or controlled with medication
- Yes No b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment
- Yes No c) Back or neck pain or injury for which further treatment or surgery has been recommended
- Yes No d) Inguinal hernia that has been repaired
- Yes No e) Inguinal hernia not repaired
- Yes No f) Umbilical hernia that has been repaired
- Yes No g) Umbilical hernia not repaired
- Yes No h) Lupus/SLE
- Yes No i) Chronic disabling arthritis
- Yes No j) Arthritis requiring daily prescription medication
- Yes No k) Osteomyelitis
- Yes No l) Joint replacement surgery
- Yes No m) Orthopedic or arthritic conditions that interfere with daily living
- Yes No n) A musculoskeletal condition not listed above

(Medical questionnaire continues on page 8.)

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

13. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any metabolic or endocrine (hormone) disorders?

- Yes No a) AIDS
- Yes No b) Diabetes controlled with oral medication
- Yes No c) Diabetes controlled with insulin
- Yes No d) Diabetes controlled exclusively with diet and exercise
- Yes No e) Gestational diabetes
- Yes No f) High cholesterol
- Yes No g) Rheumatoid arthritis
- Yes No h) Muscular dystrophy
- Yes No i) Other immunological condition
- Yes No j) A metabolic or endocrine disorder not listed above

14. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any congenital defects or developmental disorders?

- Yes No a) Down's syndrome
- Yes No b) Cerebral palsy
- Yes No c) Cleft palate or lip
- Yes No d) Club foot
- Yes No e) Congenital heart defect (specify type)
- Yes No f) Developmental delay
- Yes No g) Prematurity (for children up to 2 years old)
- Yes No h) A neurological or physical abnormality not listed above (specify)

15. **For men only: Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him) that any of you have, any of the following:

- Yes No a) Prostate condition requiring treatment, medication, or surgery
- Yes No b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months
- Yes No c) Genital warts
- Yes No d) Syphilis
- Yes No e) Gonorrhea
- Yes No f) Other sexually transmitted disease
- Yes No g) Impotence or erectile dysfunction
- Yes No h) Infertility
- Yes No i) Gender identity (role) disorder
- Yes No j) A male reproductive or genital disorder not listed above

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

16. For women only: **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or her) that any of you have, any of the following:

- Yes No a) Ovarian cyst operated on within the last 12 months
- Yes No b) Ovarian cyst controlled by birth control pills
- Yes No c) Polycystic ovary syndrome (PCOS)
- Yes No d) Endometriosis
- Yes No e) Chronic pelvic pain or pelvic inflammatory disease
- Yes No f) Painful or irregular menstrual cycles
- Yes No g) Uterine fibroids
- Yes No h) Silicone breast implants
- Yes No i) Saline breast implants
- Yes No j) Infertility
- Yes No k) Miscarriage within the last 12 months
- Yes No l) Abnormal Pap test
- Yes No m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months
- Yes No n) Genital warts
- Yes No o) Syphilis
- Yes No p) Gonorrhea
- Yes No q) Other sexually transmitted disease
- Yes No r) In vitro fertilization
- Yes No s) Heavy periods (menstruation) causing low blood iron
- Yes No t) Gender identity (role) disorder
- Yes No u) A female reproductive or genital disorder not listed above

17. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any digestive system disorders?

- Yes No a) Ulcerative colitis or Crohn's disease
- Yes No b) Gastrointestinal bleeding
- Yes No c) Gastrointestinal polyps
- Yes No d) Unrepaired cystocele or rectocele
- Yes No e) Gallstones and gallbladder has not been removed
- Yes No f) Hepatitis A, B, C, or other, currently under treatment
- Yes No g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)
- Yes No h) Cirrhosis
- Yes No i) Hepatitis A, fully recovered with no symptoms and normal liver function tests
- Yes No j) Other liver condition
- Yes No k) A digestive system disorder not listed above

(Medical questionnaire continues on page 10.)

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

18. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any urinary tract disorders?

- Yes No a) Chronic kidney failure
 Yes No b) Nephrotic syndrome
 Yes No c) Polycystic kidneys
 Yes No d) Kidney failure
 Yes No e) Chronic kidney infections (more than 2 per year)
 Yes No f) Kidney infection, resolved with no further treatment required
 Yes No g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests
 Yes No h) Kidney removed with a recommendation for further treatment
 Yes No i) Kidney stones, currently
 Yes No j) Kidney stones within the last 24 months
 Yes No k) Interstitial cystitis
 Yes No l) A kidney or urinary tract disorder not listed above

19. **Within the last 5 years**, has a medical professional advised you (or anyone you are applying for) that any of you have any abnormal lab results?

- Yes No

(If Yes, please list with patient's name[s], name[s] of test[s], result[s], and date[s] on page 13.)

20. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any blood or circulatory system disorders?

- Yes No a) Stroke
 Yes No b) Transient ischemic attacks (TIA)
 Yes No c) Hemophilia
 Yes No d) Thalassemia major
 Yes No e) Von Willebrand's disease
 Yes No f) Other blood disorder
 Yes No g) Blood pressure over 150/90
 Yes No h) Currently taking 3 or more medications for hypertension
 Yes No i) Hypertension under control with medication
 Yes No j) A blood or circulatory system disorder not listed above

21. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any cancer?

- Yes No a) Any cancer with lymph node involvement or metastasis (spread to other tissue)
 Yes No b) Cancer of the brain, breast, blood, pancreas, prostate, urinary bladder, or esophagus; or myeloma, Kaposi's sarcoma, or non-Hodgkin's lymphoma
 Yes No c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended
 Yes No d) Cancer of the colon, kidney, liver, lung, ovary, or stomach
 Yes No e) Skin cancer that has not been removed and requires further treatment
 Yes No f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended
 Yes No g) Melanoma
 Yes No h) A cancer not listed above

IV Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

22. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?

Yes No

23. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any psychological or mental health disorders?

- Yes No a) Mild depression/anxiety
 Yes No b) Major depression or neurosis
 Yes No c) Situational stress, anxiety, or depression no longer requiring treatment or medication
 Yes No d) Eating disorder (anorexia nervosa or bulimia)
 Yes No e) Suicide attempt
 Yes No f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia
 Yes No g) Hospitalization for a mental health condition
 Yes No h) A psychological or mental health condition not listed above

24. Are you (or anyone you are applying for) **regularly** taking any prescription medications?

Yes No

(If Yes, please list the person's name, the medication[s], the dosage, frequency, name/address/phone number of the prescribing medical professional, and the reason the person is taking this medication on page 13.)

25. Do you (or anyone you are applying for) drink alcoholic beverages?

Yes No

If Yes, please indicate how much you (or anyone you are applying for) drink **per week** and provide his or her name: _____

- Yes No a) Beer: _____ bottles/cans
 Yes No b) Wine: _____ glass
 Yes No c) Hard liquor: _____ glass

On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.

(If more than one person drinks, please list separately on page 13 the person's name and the amount consumed, using the format above.)

26. Are you (or anyone you are applying for) **currently** pregnant or an expectant father? Or, do you (or anyone you are applying for) **expect to be providing** medical insurance coverage for a newborn or new adoptee within the next 9 months?

Yes No

27. Do you (or anyone you are applying for) plan to be a surrogate parent (mother or father) **within the next year** or to engage someone to provide that service **within the next year**?

Yes No

(Medical questionnaire continues on page 12.)

IV Kaiser Permanente for Individuals and Families Medical Questionnaire *(continued)*

28. For females age 11 and older:

Please answer the questions below and provide your name: _____

- Yes No a) Have you ever menstruated?
- Yes No b) Are your menstrual periods regular? (If you answered No, please explain on page 13.)
- Yes No c) Are you still having regular menstrual periods? (If you answered Yes, please indicate the date you started your last normal menstrual period on page 13.)

(If this question pertains to more than one family member, please list additional name[s] and answers on page 13, using the format above.)

29. Have you (or anyone you are applying for) been treated for, or advised that you have, a medical or health-related condition which you haven't indicated on this Medical Questionnaire? If so, please provide the appropriate details on the chart on page 13.

- Yes No

V Broker Authorization

FOR APPLICANTS USING AN INSURANCE BROKER/AGENT

Broker/Agent name _____

Yes No Did you receive assistance from a broker/agent in filling out this application?

I understand that the broker of record may receive monetary and/or non-monetary payments from Kaiser Foundation Health Plan in connection with the purchase of this health plan coverage.

Note: Premiums are the same whether or not you use a broker/agent.

X

Applicant signature (Use ink only.) **Today's date**

TO BE COMPLETED BY YOUR KAISER PERMANENTE-APPOINTED BROKER/AGENT AFTER COMPLETION OF THIS APPLICATION

Yes No 1. Are you aware of any information not disclosed on this application relating to the health or health habits of any person listed on this application which might have a bearing on the risk?

Agent name (please print)

Yes No 2a. Were you present and did you witness the applicant(s) executing this application?
Please answer the following question *only* if you answered Yes to 2a.

Agent ID #

2b. Do you verify that this application was completed by the applicant(s)?

Address

Yes No

City State ZIP

Phone Fax

E-mail address

X

Broker/Agent signature (Use ink only.) **Today's date**

The head of household (or subscriber) and spouse, if applying together, must complete, sign, and date this page for their applications to be considered complete.

VI Business Group of One Determination Form

Please complete and sign this form to determine if you are a self-employed Business Group of One.

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you or your spouse either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you or your spouse have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that is sufficient to pay for the annual premiums for the Business Group of One's health benefit plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?

Please sign below

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of applicant _____ Date _____

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of spouse _____ Date _____ Applicant's or spouse's business _____

If you or your spouse answered Yes to all four questions listed above, please complete and sign the following Business Group of One Disclosure Form.

VII Business Group of One Disclosure Form

Please read and sign the following disclosure required by Colorado law:

I, _____, meet the definition of a self-employed Business Group of One as attested to on the accompanying *Business Group of One Determination Form*. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group Business Group of One policy are limited to plan design, the carrier's overall cost and utilization trends (*index rate*), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a *Colorado Health Plan Description Form* for the plan for which I am applying.

Applicant's name _____ Applicant's signature _____

Applicant's business _____ Date _____

(This page is intentionally left blank.)

VIII 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 Dr.

Last name

First name

MI

Street address

Apt./Unit #

City

State

ZIP

2. Effective date:

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

- 1st of the month immediately following the date the application is approved (application must be received by the 23rd of the preceding month)
- 15th of the month following the date the application is approved (application must be received by the 8th of the month of intended enrollment)
- 1st of the month plus one additional month following the date the application is approved (application must be received by the 23rd of the preceding month)
- 15th of the month plus one additional month following the date the application is approved (application must be received by the 8th of the preceding month)

3. Credit/debit card information: Credit Debit

Visa

MasterCard

Discover

American Express

Name as it appears on card

Credit/debit card number

Credit/debit card security number (Usually this is a three- or four-digit code on the back of the card near the signature line. In some cases it may be on the front of the card.)

Expiration date

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.

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All Applicants: Please read the following information and sign in the space below.

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative at 1-800-634-4579 before signing this application.

IX Conditions of Acceptance

You must fully answer each question in this application even though you may already be a Health Plan member. If we decide to accept you for KPIF membership, our decision would be based primarily on health information you provided in your application and would be conditioned on your actual health being consistent with the information you provided. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician to clarify your specific condition.

If you are a present or former Health Plan member, we will review your prior health history with Kaiser Permanente before making our decision. We reserve the right to review your use of health services during your first year of membership to confirm consistency with your pre-enrollment health information.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or a dependent, take the time to make sure the information is accurate before submitting it to us.

Note: If we discover that you intentionally provided incomplete or incorrect material information in the enrollment process, we will rescind your membership. This means that we will completely void membership so that no coverage ever existed. You will have to pay as a nonmember for any services we covered.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf.

Important note to the Applicant: You or your authorized representative may request a copy of your completed application. For more information, please call **1-800-634-4579**.

X

Applicant/Head of household

Today's date

X

Applicant's spouse

Today's date

X

Applicant/Dependent (age 18 or over)

Today's date

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. **Use ink only.**

X Insurance Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

XI 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 me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product (each, an *Applicant*) to give Kaiser Foundation Health Plan of Colorado, 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 or emotional disorders, sexually transmitted diseases, HIV (human immunodeficiency virus) status, AIDS (acquired immune deficiency syndrome), or ARC (AIDS-related complex) (Medical Information)** of the Applicant. 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 Kaiser Permanente 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 Kaiser Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; 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, Kaiser Permanente may request, use, and disclose any Medical Information, HIV/AIDS- or ARC-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 twenty-four (24) months. A photocopy of this authorization is as valid as the original, and I and my Kaiser Permanente agent or broker 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 Kaiser Permanente has already taken action in reliance on it, or for so long as Kaiser Permanente may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations is in Kaiser Permanente's *Notice of Privacy Practices*.

X
 Applicant/Head of household _____ Today's date

X
 Applicant's spouse _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. In addition, all Applicants age 12 or over must sign and date above on the appropriate signature line. **Use ink only.**

XII Kaiser Foundation Health Plan Arbitration Agreement

Except for: (1) claims filed in Small Claims Court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the *Medicare Managed Care Manual*; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians (“respondent[s]”), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Note: Any intentional misrepresentation of your current health status may void your coverage and the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

X

Applicant/Head of household

Today's date

X

Applicant's spouse

Today's date

X

Applicant/Dependent (age 18 or over)

Today's date

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. **Use ink only.**

XIII Information about CoverColorado

Colorado residents who do not qualify for Kaiser Permanente for Individuals and Families plan may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. CoverColorado does not impose pre-existing conditions or limitations on coverage. For information about CoverColorado, please contact that agency directly at:

CoverColorado
425 S. Cherry Street, Suite 160
Glendale, CO 80246
(303) 863-1960
covercolorado.org

For office use only:	PH 0	CSC 0	Area No. _____
Medical Record No. _____	Family Account No. _____	Purchaser No. _____	
Date Received _____	Status: 0 Approved 0 Denied	Effective Date _____	