



Small Group Enrollment Packet

Kaiser Permanente Health Insurance Coverage for Georgia

Follow these seven easy steps to complete your enrollment for Kaiser Permanente group coverage.

KAISERQuotes
[.com](http://www.kaiserquotes.com)

phone: 1.877.752.4737
facsimile: 1.866.439.9993

Follow These Easy Steps to Enroll...

For Kaiser Permanente Small Group Coverage

- Small Group Employer Application**
Please complete and sign the application.
- Employee Enrollment Forms**
Submit one *4-page* form for all eligible employees. Employees who wish to waive coverage may leave page 2 blank.
- Official Business Document**
Include a copy of your DOL-4 Quarterly Tax and Wage Report (If you've been in business under 3 months, you may use a copy of your payroll. Non-Profits must include Form 941 along with payroll.). Please note the status for each person listed (*i.e. full-time, part-time, terminated, or waiving coverage*).
- Copy of previous Carrier Bill**
- Company Check for First Month's Premium**
- Fax a Copy of the Above Items to:** 1-866-439-9993
- Keep Copies of Original Forms**
Original copies must be mailed in at a later time.

Notes:

- Enrollment applications must be completed in all required fields including date of hire and hours worked. This information is not optional and will be requested if not submitted on the front end. The enrollment application must also include height and weight information.
- Owners and partners must actively participate in the business in order to be enrolled.
- Covered dependents ages 19-25 must be full time college students and must submit the Student Certification Form on page 11.
- Your Authorized Broker is: KaiserQuotes.com (William Hansen - RAJ) Phone: 1-877-752-4737 Fax: 1-866-439-9993



KAISER PERMANENTE®

SMALL GROUP EMPLOYER APPLICATION
(FOR GROUPS WITH 2-50 ELIGIBLE FULL-TIME EMPLOYEES)

This form must be completed and signed by the employer. This application is subject to review and approval by the Health Plan and/or KPIC, as applicable.

Please Note: Statements made in the application form are deemed representations and not warranties.

Section 1. Employer Information

Firm Name

Address

City State Zip

County Tax ID #

SIC Code

Billing Address, if different from the above

Address

City State Zip

Key Contact (person to whom correspondence should be directed at employer's place of business)

First & Last Name

Telephone Number

Describe nature of business, including primary services and products.

E-mail Address

Corporation Partnership Proprietorship
Number of years in business _____

Section 2. Prior Coverage

Is this application made to replace any existing group insurance?

Yes No

Name of existing or prior group insurance carrier:

Number of insurance carriers your group has been insured with in the past three years: _____

Policy number or case number of prior or existing group insurance: _____

Has group had prior coverage within last 12 months?
Yes No

Date prior coverage terminated (mm/dd/yy) ____ ____ ____

A copy of your most recent billing statement must be submitted with this application.

Section 3. Eligibility

Effective date desired (mm/dd/yy) _____/_____/_____
(In no instance may coverage be backdated.)

Present eligible, full-time employees to be insured:
Immediately, subject to approval by Health Plan and/or
KPIC, as applicable

The first of the month following _____ days from the
first day of work (waiting period).

Future eligible full-time employees will be eligible to be
insured the first day of the month following _____ days
from the first day of work (minimum 30 days). Employees who
are eligible to be insured at the time of employer's original
enrollment and who are approved by Health Plan and/or
KPIC, as applicable will be insured on the effective date spec-
ified above in this agreement, if approved by the Health Plan
and/or KPIC, as applicable. All other full-time employees may
be eligible to be insured the first of the month after the wait-
ing period expires. The effective date will be the first of the
month following receipt and approval by Health Plan and/or
KPIC, as applicable of sign-ed and properly completed
Employee Enrollment Application and Change Form and such
additional information as may be required. All employees and
dependents who are not original enrollees are subject to the
requirements and conditions specified in the administrative
information which will be sent to the employer upon approval
and issuance of coverage by Health Plan and/or KPIC, as
applicable.

Health Plan and/or KPIC, as applicable reserves the right to
require such additional information including medical records
and questionnaires that it deems necessary before approving
and issuing any coverage for any present or future employee
or dependents.

Total number of eligible, full-time employees: _____

Number of eligible, full-time
employees applying for coverage: _____

Total number of ineligible part-time employees: _____

Number of eligible full-time employees
waiving coverage: _____

Has anyone in your group currently exercised their rights
under COBRA, is currently totally disabled, on disability
retirement, or extended sick leave?

No Yes

Name

Does your company have separate locations,
affiliates, or subsidiaries?

No Yes Please list them below:

Name

Location

Number of employees _____

Number covered on this plan _____

If there are additional addresses, please list them on a
separate sheet.

Section 4. Agreements

The undersigned employer hereby certifies that the firm
indicated employs _____ full-time (equivalent to 30 hours per
week or more) employees and that no part-time employees
have been included for coverage. The employer agrees to
contribute toward the premium cost the following percent-
ages: _____ % for employees, _____ % for dependents.
The employer must contribute a minimum 50% (groups of
6-50 eligible employees) or 75% (groups of 2-5 eligible
employees) toward the employee portion of monthly premium.
The employer understands the licensed broker, if any, who
solicited this application was acting as an independent con-
tractor and not as a broker of the Health Plan and/or KPIC,
as applicable. Furthermore, the broker who solicited this
agreement or upon whose explanation of coverage and
benefits employer relied is in fact employer's broker for
purposes of this agreement. It is understood that as an
independent contractor and as employer's broker that person
has no right to bind this coverage or to alter terms or con-
ditions of any policies or any enrollment applications or
to waive any requirements of Health Plan and/or KPIC, as
applicable or to adjust any claims for benefits under this

insurance for which employer is applying. The employer
acknowledges and agrees that: coverage under any policy
will only be as and to the extent provided and it is employer's
duty and responsibility to explain this to each person for whom
coverage is sought. Employer has reviewed the benefits and
limitations of coverage in the benefits summary and has
explained such benefits and limitations to each person for
whom coverage is sought. It is also acknowledged and agreed
that coverage will begin only: (1) if this agreement is approved
by Health Plan and/or KPIC, as applicable, (2) if written notice
of approval is received by employer, and (3) upon the effective
date inserted by Health Plan and/or KPIC, as applicable in the
approval form and in the written notice of approval to employ-
er. The absence of written approval will not imply approval.

Employer may cancel this agreement at any time upon 30 days
prior written notice to Health Plan and/or KPIC, as applicable.
For the duration of coverage, employer agrees to pay premi-
ums on a monthly basis or at such other frequency as agreed
upon by Health Plan and/or KPIC, as applicable. If Health Plan
and/or KPIC, as applicable does not receive payment in full
within the time allowed, this will automatically constitute with-

drawal and cancellation of all coverage. The effective date of coverage termination will be 12:01 a.m. of the first day of the billing period for which the premium was not paid when due if: (1) coverage is terminated because of nonpayment of premium in full; or (2) employer has not given prior written notice of cancellation. Coverage for the participating employees and their dependents will be continuous unless (1) the employee terminates employment; (2) the employee or dependent ceases to be eligible; or (3) requirements of this agreement are not maintained by the participating parties hereunder, including employer and employees. Employer agrees that the terms and benefits of the policies may be amended, modified, or changed at any time upon 60 days prior notice to employer. The employer is establishing this plan to provide medical and

other benefits to its eligible employees and dependents. Employer acknowledges that this plan constitutes an employee welfare benefit plan and agrees, as "sponsor", to fully comply with the applicable provisions and requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Employer designates Health Plan and/or KPIC, as applicable, as the named fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the administrator of employer's employee benefit plan as that term is defined under ERISA. This provision only applies to an employer who sponsors an employee welfare benefit plan covered by ERISA, and where Health Plan's and/or KPIC's group health coverage is a component of that employee welfare benefit plan.

Section 5. Benefits desired

	<u>HMO</u>		<u>MULTI-CHOICE</u>	<u>MULTI-CHOICE</u>	<u>OUT-OF-AREA PPO</u>
	<u>PLANS</u>		<u>PLANS</u>	<u>MAX PLANS</u>	<u>PLANS</u>
Single Option	Plan A	Plan F-100	Plan A	Plan A	Plan A
Dual Option	Plan B	Plan G-100	Plan B	Plan B	Plan B
	Plan C	Plan H	Plan C	Plan C	Plan C
	Plan D	<u>[PRESCRIPTION DRUG COVERAGE]</u>	Plan D	Plan D	Plan D
	Plan E	\$15/\$25	Plan E	Plan E	Plan E
	Plan F	\$20/\$30	Plan F		
			Plan G		
			Plan H		
			Plan I		
			Plan J-100		
<u>DEDUCTIBLE PLAN WITH HSA OPTION</u>					
	Plan A				
	Plan B				
	Plan C				
	Plan D				
	Plan E				

HMO plans (including Deductible Plans), and the [Select provider] benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). The [PPO provider and Non-participating provider] benefit levels of the Multi-Choice plans and Out-of-Area Indemnity plans are underwritten by Kaiser Permanente Insurance Company (KPIC).

Section 6. Request for coverage

We hereby apply for the group benefits set forth in the benefit summary brochure. We understand that the following conditions must be met before insurance becomes effective, and must continue to be met. To be eligible:

- 1) Employees must be full-time, earning compensation equal to a minimum of the Federal minimum wage for 30 hours per week or more.
- 2) This agreement must be accepted and approved in writing by Health Plan and/or KPIC, as applicable.
- 3) The following enrollment percentages must be met and continuously maintained:

Firms with two or three eligible employees must maintain 100% participation for health coverage of all eligible employees.

Firms with four through 50 eligible employees must maintain 75% participation for health coverage of all eligible employees.

Any employees who are covered for health care under Champus/Champva, Medicare or their spouse's group cover-

age may waive health coverage. The participation schedule would apply to the remaining eligible employees. The employer will (1) maintain the records necessary to the administration of the agreement; (2) report additions, changes, terminations and other information necessary to the administration of the agreement to Health Plan and/or KPIC, as applicable within 30 days after the effective date of such additions, changes and terminations; (3) agree that if employer does not notify Health Plan and/or KPIC, as applicable of any insured ineligibility or termination within 30 days, shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax return, and personnel files and other documentation as determined by the Health Plan and/or KPIC, as applicable available upon request to the Health Plan and/or KPIC, as applicable or its authorized representative; (5) pay all premiums in accordance with the terms of this agreement; and (6) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate premium.

Section 7. Signature

All statements provided in this agreement are true, correct, complete, and within our personal knowledge. We have read and understood this agreement. We understand and agree that this agreement will become binding between Health Plan and/or KPIC, as applicable and us only upon acceptance by Health Plan and/or KPIC, as applicable. The absence of written approval will not imply approval. Any intentional material misstatement or incomplete statement of fact will be deemed a misrepresentation and will result in termination of all coverage with respect to us, our participating employees and their dependents without liability to the insurer.

Signed this _____ day of _____

City _____ State _____

By (Signature of Authorized Company Officer)

Title

Premium deposit collected: \$ _____

Authentication Code for CAS
(Any 4 to 10 letters and/or numbers)

Name of Employer

John Hansen

Witness (Signature of Licensed Broker)

William Hansen

Please Print Broker Name

Broker Designation: I hereby designate

William Hansen _____ as the broker of record.
(Broker Name)

Signature of Authorized Company Officer

Date

For Health Plan and/or KPIC, as applicable, Use Only:

Approved by

Date Month/Day/Year

Effective Date Month/Day/Year

Section 8. Writing Broker Information

(Please check box if this is to replace address currently on file.)

William Hansen

Writing Broker's Name

750 Mendocino Ave Suite 4

Street Address

707-571-7590

Area Code Telephone Number

707-571-7441

Fax

750 Mendocino Ave Suite 4

Mailing Address

Santa Rosa, CA 95401

State Zip

Social Security Number or Tax I.D. Number

support@kaiserquotes.com

Broker's E-mail Address

Georgia

Broker's License: State

728507

License Number

Broker's Statement:

To the best of my knowledge and belief, all medical history, employment, and other information supplied in the group enrollment application is true and complete. I acknowledge that I represent and am acting on behalf of my client and not for or as an employee of Kaiser Foundation Health Plan or KPIC. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance concerning incomplete or additional underwriting information.

John Hansen

By (Writing Broker's Signature)

Date Month/Day/Year

General Agent Stamp

RAJ



Small Group **Employee Enrollment Form** with Medical Review

Check Plan Type:

- HMO
- Multi-Choice
- Out-of-Area PPO
- Deductible Plan with HSA option

Check Enrollment Type:

- Annual Enrollment
- COBRA Enrollment
- Waive Coverage

Fill Out Sections:

- A, B, C, D, E
- A, B, C, D, E
- A, D, E

To be Completed by Employer:

Effective Date _____ Group Number _____ Sub Group _____ Bill Group _____

A. Employee Information Note: Please print and use blue or black ink. Language Preference _____

Last Name _____ First Name _____ MI _____ Gender M F

Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Job Title _____ Height _____ Weight _____ Marital Status Married Single

Please select Primary Care Physician _____ Physician ID # Check if you are an existing patient.

Company Name _____ Date of Employment _____ Hours Worked _____

Employment Status: Active Retired Disabled COBRA Are you an independent contractor? YES NO

Consumer Choice Option (CCO)? YES NO *If yes, an additional premium will apply.*

B. Coverage Status Self Only Self + Spouse Self + Spouse + Child(ren) Self + Child (ren)

SPOUSE

Last Name _____ First Name _____ MI _____ Height _____ Weight _____

Date of Birth _____ Gender M F Social Security Number _____ Physician ID # Check if an existing patient.

DEPENDENT 1

Last Name _____ First Name _____ MI _____ Height _____ Weight _____

Date of Birth _____ Gender M F Social Security Number _____ Physician ID # Check if an existing patient.

College Student? YES NO School _____ Disabled? YES NO

DEPENDENT 2

Last Name _____ First Name _____ MI _____ Height _____ Weight _____

Date of Birth _____ Gender M F Social Security Number _____ Physician ID # Check if an existing patient.

College Student? YES NO School _____ Disabled? YES NO

DEPENDENT 3

Last Name _____ First Name _____ MI _____ Height _____ Weight _____

Date of Birth _____ Gender M F Social Security Number _____ Physician ID # Check if an existing patient.

College Student? YES NO School _____ Disabled? YES NO

C. Health Questions

All applicants must complete this section. Please answer all questions completely and in ink. Sign and date any changes made or additional pages you may attach. If the answer to any of the following questions is "Yes," please provide details below. If you have questions, please contact your broker.

Note: Coverage is offered on a guaranteed acceptance basis. Medical information you provide cannot be used to deny coverage. However, accurate information about an applicant's health status is necessary for risk management purposes. Material misrepresentation or omission of information may be the basis for later rescission of health coverage.

Health questions 1-15 are to be answered for all groups enrolling 2-19 employees (and groups of 20-50 employees without prior group health coverage).

In the **last five (5) years**, have you or anyone applying for coverage been diagnosed with, received medical advice concerning, or been seen or treated by a member of the medical profession for any of the following conditions?

1. YES NO Arthritis, back, neck, or spinal injury, lupus, limb loss?
2. YES NO Asthma, emphysema, lung disorders, tuberculosis?
3. YES NO Epilepsy, stroke, or paralysis?
4. YES NO Sexually transmitted disease?
5. YES NO Mental, nervous, or compulsive disorders?
6. YES NO Substance abuse problem or alcoholism?
7. YES NO Autoimmune disease, or other condition or infection related to AIDS, HIV?
8. YES NO Bladder, kidney, liver (including hepatitis), prostate, or reproductive disorders?
9. YES NO Diabetes, blood disorders, or Sickle Cell Anemia?
10. YES NO Cancer, tumors, thyroid, or glandular disorders?
11. YES NO Circulatory disorder, chest pain, heart disease, heart murmur, mitral valve prolapse, or high blood pressure?
12. YES NO Digestive and/or intestinal disorders?
13. YES NO Currently pregnant or an expectant parent? If yes, due date _____
14. YES NO Any hospitalizations or planned surgeries?
15. YES NO Current medications prescribed?

Health question 16 is to be answered for groups enrolling 20-50 employees with prior group health coverage.

In the **last two (2) years**, have you or anyone applying for coverage been diagnosed with, received medical advice concerning, or been seen or treated by a member of the medical profession for any of the following?

16. YES NO AIDS/HIV, or any disease, condition, or infection related to AIDS/HIV, alcoholism and/or substance abuse, cardiovascular or heart disease, chest pains, cancer, diabetes, digestive and/or intestinal disease or disorder, kidney disease or disorder, liver disease or disorder, mental or nervous disorder, neurological disease or disorder, pancreatitis, stroke, and/or is anyone applying for coverage currently pregnant or an expectant parent, or have planned or recommended surgeries.

If you checked "YES" to any of the health questions above, provide details below. If additional space is needed, attach a separate sheet with details, sign, and date.

Question	Name	Treatment/ Diagnosis	Hospitalized	List all Medications	Dates	Is further treatment needed?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

By signing below, you verify all health questions above (if required to complete) have been answered correctly for all applying for coverage. (Another signature is required on page 4 of this application.)

Signature of Employee _____ Date _____

D. Waiver of Coverage/Other Coverage Information

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer.

I refuse the following: All coverage Coverage for my spouse Coverage for my children

Reason for refusal: (Please check all appropriate boxes)

- Other group coverage sponsored by my employer Other reason (please explain) _____
- Other group coverage sponsored by my spouse's employer _____
- Other group coverage sponsored by another organization _____

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit an Employee Enrollment Form and coverage may be subject to late enrollee provisions, as allowed by law.

Do you or any dependents have any other medical insurance? (check one) YES NO

Do you or any dependents currently receive Medicare benefits? (check one) YES NO

Insurance Company Name _____

Policy Number _____

Insurance Company Address _____

Policy Holder _____

City _____ State _____ Zip Code _____

Policy Holder Date of Birth _____ - _____ - _____

E. Please sign application on the reverse side of this form.

Please complete this application and submit it to your company's Benefits Administrator. I understand and agree that if the application is accepted by Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, my spouse, and dependents (if any) will be eligible will be in accordance with the Group Agreement and/or Group Policy, as applicable to the type of plan for which we are enrolled. I further understand and agree that I, my spouse, and dependents (if any) will be bound by the terms and conditions of such agreements. I authorize the deduction from my wages, amounts necessary to pay the employee portion of the premiums for my, my spouse's, and covered dependents' (if any) Health Plan and/or KPIC, as applicable, coverage. I understand that to be eligible for coverage and remain eligible, I must satisfy the eligibility requirements set forth in my employer's agreement with Health Plan, and that the information provided in this application may be relied on and used to determine my, my spouse's, and my dependents' (if any) eligibility for such coverage.

I agree to provide any documentation, including tax returns, payroll records, etc. necessary to establish that I, my spouse, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:
 - a. The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.
 - b. Any unmarried, dependent child of the subscriber or the subscriber's spouse, or an unmarried, dependent child who is claimed on the subscriber's federal tax return and is under the group's age limit for dependent status.
2. Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Evidence of Coverage*.
3. Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.
4. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Customer Service at **(404) 261-2590** before signing this application.

Personal Information

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy.

I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, Georgia 30305.

NOTICES:

1. I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the rescission of my coverage, as well as the coverage of my spouse and covered dependents (if any), without liability to Health Plan and/or KPIC, as applicable, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.
2. You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, GA 30305.
3. This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at kp.org. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Customer Service at **(404) 261-2590**.
4. HMO plans and the Kaiser Permanente Select Provider benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company

IMPORTANT: Please read the conditions above, and sign and date below. All applications MUST be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

Signature of Employee

Date

E-mail Address (optional)

Student Certification

Requirements for dependent student coverage:

- Full-time student in an accredited institution
- Dependent upon subscriber for support
- Unmarried
- Under 26 years of age

Dependent's name Dependent's Medical Record Number

Birth date Dependent's Social Security number

School name

School address City, state, zip

Student ID number Number of units carried

Subscriber's name Subscriber's Medical Record Number

Purchaser ID

I certify that the dependent shown above meets all of the requirements for coverage on my account as a full-time student. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

X

Subscriber's signature

Social Security number

Date

Employee: Return to Employer

Employer: If Kaiser Permanente certifies your students, return this form to your membership document address.