

Wait!

**Please call before
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

1 800 721-2618

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency
1344 Disc Dr. #210
Sparks, NV 89436
Attn: APDT

Or you may fax your application to:

800 905-6750



KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES MEMBERSHIP APPLICATION

NOTE: You must fully answer each question in this application even though you may already be a Health Plan member. Omissions will delay processing of your application. Inaccurate answers can result in revocation of your Health Plan membership. This application may become part of your permanent medical record if your membership is approved. It may be reviewed again with you by a physician.

I. EACH PERSON IN THE FAMILY MUST COMPLETE A SEPARATE APPLICATION FOR MEMBERSHIP

A. Height (without shoes): [] Ft. [] In. Weight (dressed): [] Lbs.

B. Male Female

C. Single Married Domestic Partner (Please refer to DF/EOC for eligibility)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last Name [] First Name []

Previous Medical Record Number []

E. Membership Application for:

Last Name []

First Name [] M.I. []

Mr. Mrs. Miss Ms. [] []

F. Date of Birth []

1. How many times have you been hospitalized in the last 12 months, except for pregnancy?

- Never 2 times
 1 time 3 or more

2. How many times have you required medical attention in the last 12 months, except for pregnancy?

- 0-2 times 6-8 times
 3-5 times 9 or more

3. Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?

- Yes No

4. (a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?

- 1/2 pack or less 2 or more packs
 1 pack N/A
 1 1/2 packs

(b) For how long?

- 9 years or less 20-29 years
 10-14 years Over 30 years
 15-19 years N/A

5. In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?

- Yes No

6. In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?

- Yes No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (please check all that apply):

- AIDS, ARC Painful menstrual cycle or female reproductive disorder
 Sexually transmitted diseases Hepatitis disorder
 Hernia not repaired/ GI reflux Lupus/SLE
 Back/Neck pain or injury Silicone breast implants
 Bone marrow transplant Melanoma/ Breast/Prostate/ Bladder cancer
 Crohn's or ulcerative colitis Skin cancer
 Depression or anxiety Other cancers
 Mental health condition Aneurysm
 Eating disorder, anorexia nervosa/bulimia MS/ALS/ Parkinson's/ Alzheimer's
 Heart or valve condition Neurologic condition
 Asthma Pacemaker
 Emphysema/COPD Prostate condition
 Lung condition, other chronic condition Rheumatoid arthritis
 High blood pressure Seizures
 High cholesterol Sickle cell anemia
 Kidney/Bladder condition incl. kidney stones Diabetes
 Liver condition Stomach or intestinal problems
 Gallstones Stroke
 Anemia or other blood disorder Lumps
 Ulcer

Other conditions not specifically listed on application []

None of the above

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

- Yes No

8. (b) If Yes, what was the type and quantity consumed daily?

- Beer: None or less than 32 oz. 32 oz. or more
Wine: None or less than 18 oz. 18 oz. or more
Hard: None or less than 4 oz. 4 oz. or more

9. Do you have unexplained and/or undiagnosed symptoms such as (please check all that apply):

- Fever Rectal bleeding
 Swollen glands Loss of appetite
 Chest pain Dizziness
 Shortness of breath Chronic fatigue
 Abdominal or pelvic pain Rash
 Loss of consciousness Skin lesions
 Unexplained weight loss Lumps
 Other []
 None of the above

10. Are you currently taking birth control medication, estrogen, Premarin, Depo-Provera, etc.?

- Yes No

11. (a) Are you regularly taking any prescription medications other than those in question 10?

- Yes No

(b) If Yes, please list each medication below:

[]

12. Are you an expectant parent?

- Yes No

13. For females over age 11 only:

(a) Are you pre-menstrual (have never menstruated), post-menopausal, or have you had a hysterectomy or tubal ligation?

- Yes No

(b) If No, date of your most recent normal menstrual period:

[] / [] / []
month day year

II. BILLING INFORMATION (HEAD OF HOUSEHOLD ONLY)

Only the Head of Household must complete Section II - Billing Information and Section III - Family to be Covered.

1. Person to be billed

Last Name

First Name

M.I.

- Mr. Mrs.
- Miss Ms.

Date of Birth

Social Security Number or Taxpayer I.D.

Street Address

Apt. No.

City

State

ZIP Code

2. Account Information

- Addition of a family member to an existing account
- Switching coverage from an existing account
- New account

3. For which plan would you like to apply?

- \$1,500 Deductible Plan
- \$250 Deductible Plan
- \$50 Copayment Plan
- \$25 Copayment Plan

4. Are you applying for the optional dental plan?

- No Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente Medical Record Number:

6. Home Phone:

7. Work Phone:

For Brokers Only

8. Broker Name:

9. Broker ID:

III. FAMILY TO BE COVERED (OTHER THAN HEAD OF HOUSEHOLD)

EACH PERSON IN THE FAMILY MUST COMPLETE A SEPARATE APPLICATION FOR MEMBERSHIP

Relationship	Name - Last	First	M.I.	Date of Birth	Sex (M/F)	S.S.N.
Spouse	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____

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 Services representative at 1-800-634-4579 before signing this application.

IV. HEALTH STATUS UPDATE

NOTICE: You must immediately inform us if your health status or current medication changes at any time before your membership in Kaiser Permanente for Individuals and Families becomes effective. Failure to inform us of such change can void your Health Plan membership. Any omission or misrepresentation of your current health status may void your Health Plan coverage and the coverage of your family members and preclude any future opportunity to enroll as a Kaiser Foundation Health Plan member. You can choose to update your application information by telephone 1-800-634-4579, by fax 1-800-369-8010, or by writing to us at Kaiser Foundation Health Plan, Individual Programs, 393 E. Walnut Street, LsRs-5, Pasadena, CA 91188-8539, Attention: Health Status Update. All written and fax correspondence must be signed and dated by the subscriber.

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.

V. AUTHORIZATION TO REVIEW EXISTING INFORMATION

I hereby authorize Kaiser Foundation Health Plan to review any existing Kaiser Permanente medical records and history of care provided to me or my dependents as members of Kaiser Foundation Health Plan for a period of up to 5 years preceding this application for membership in the Kaiser Permanente for Individuals and Families Plan. This authorization applies to all types of care including the diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, or AIDS-related condition, and is limited to information reasonably related to determining my/our eligibility for membership in the Kaiser Permanente for Individuals and Families Plan. I understand that Kaiser Foundation Health Plan will not redisclose any information received through this review except with my written consent or as permitted by federal and/or state laws and regulations. This authorization for review is effective during all times that my/our application and/or eligibility status are being considered. If accepted as a Kaiser Permanente for Individuals and Families member, I further authorize Kaiser Foundation Health Plan, without limitation and including all categories of care stated above, to review my Kaiser Permanente medical records, including pharmacy records, for a period of up to 12 months following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application.

VI. KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled through a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Evidence of Coverage*.

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.)

To apply for membership, YOU MUST SIGN HERE.

X	Date
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Applicant's signature if 18 or older or emancipated minor (otherwise, Parent/Legal Guardian signature required)
USE BLACK INK ONLY.

Please continue on page 4

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 _____

VII. HIPAA ELIGIBILITY QUESTIONNAIRE AND REQUEST FOR ENROLLMENT

Notice to applicants in Kaiser Permanente regions **other than Colorado* and Georgia****:

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the following five requirements. Please complete this application and return it with pages 1-3 so that your eligibility for individual coverage under HIPAA can be determined. This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families coverage but meet ALL of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan with benefits most like the Kaiser Permanente for Individuals and Families plan to which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA-qualified plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA-qualified plan only if you meet HIPAA eligibility requirements, and only if your Kaiser Permanente for Individuals and Families application is declined. If you qualify for both plans, we will enroll you in Kaiser Permanente for Individuals and Families. Both plans will have the same benefits (except in Maryland and Ohio), but Kaiser Permanente HIPAA Plan (KP HIPAA Plan) rates may be significantly higher than Kaiser Permanente for Individuals and Families rates. Information on your specific KP HIPAA Plan rates is available by calling 1-800-464-4000.

***Colorado residents** who do not qualify for Kaiser Permanente for Individuals and Families may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, you may be eligible for CoverColorado now 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 them directly at:

CoverColorado
 420 S. Cherry Street, Suite 160
 Denver, CO 80246
 (303) 863-1960

****Georgia residents** who do not qualify for Individuals and Families and are not current Kaiser Foundation Health Plan members may be eligible to participate in the state of Georgia Health Insurance Assignment System, a state-sponsored guaranteed-issue health care coverage program in which Kaiser Permanente participates. Please contact the Georgia Office of Insurance and Safety Fire Commissioner at 2 Martin Luther King Dr., Atlanta, GA 30334 or at 1-800-656-2298 to obtain information on this program. Georgia residents who do not qualify for Individuals and Families and who are current Kaiser Foundation Health Plan members can choose to be automatically considered for our Enhanced Conversion Plan, our guaranteed-issue health care coverage program available to HIPAA-qualified individuals. If you wish to exercise that option, please contact our Member Services Department at 1-800-634-4579 to obtain an application. There is no need for you to complete the following questionnaire. Non-Health Plan members must go through the state of Georgia program.

QUESTIONNAIRE

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. (Refer to the *Membership Agreement and Disclosure Form and Evidence of Coverage* in this booklet for "significant break in coverage rules" to determine if you have 18 months.)
2. My most recent health care coverage was through a group health plan, a governmental plan or a church plan.
For Virginia residents: My most recent health care coverage was through individual coverage, a group health plan, a governmental plan or a church plan.
3. I have both elected and exhausted all continuation health care coverage available under Federal (COBRA) and state continuation coverage laws.
4. I do not currently have other health care coverage and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was NOT terminated for fraud or failure to pay premiums.

Please answer the following three questions:

- | | | |
|---|-------|------|
| i. I have read the above five statements and attest that each of them is completely true. If I answered "No," I understand that I do not qualify for KP HIPAA Plan. | 0 Yes | 0 No |
| ii. If I do not qualify for Kaiser Permanente for Individuals and Families and I qualify for KP HIPAA Plan, I request that I be enrolled in KP HIPAA Plan. If "Yes," please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in KP HIPAA Plan may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership. | 0 Yes | 0 No |
| iii. I have attached proof(s) of creditable coverage. | 0 Yes | 0 No |

X	
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Signature

Date