



MEMBERSHIP APPLICATION: KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES

NOTE: 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. You must answer all questions completely. Omissions will delay processing of your application.

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

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

B. 0 Male 0 Female

C. 0 Single 0 Married

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. 0 Mr. 0 Mrs. 0 Miss 0 Ms.

F. Date of Birth

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

- 0 Never 0 2 times 0 1 time 0 3 or more

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

- 0 0-2 times 0 6-8 times 0 3-5 times 0 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?

- 0 Yes 0 No

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

- 0 1/2 pack or less 0 2 or more packs 0 1 pack 0 N/A 0 1 1/2 packs

(b) For how long?

- 0 9 years or less 0 20-29 years 0 10-14 years 0 Over 30 years 0 15-19 years 0 N/A

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

- 0 Yes 0 No

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

- 0 Yes 0 No

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):

- 0 AIDS, ARC 0 Painful menstrual cycle or female reproductive disorder 0 Sexually transmitted diseases 0 Hepatitis 0 Hernia not repaired/ GI reflux 0 Back/Neck pain or injury 0 Bone marrow transplant 0 Crohn's or ulcerative colitis 0 Depression or anxiety 0 Mental health condition 0 Eating disorder, anorexia nervosa/bulimia 0 Heart or valve condition 0 Asthma 0 Emphysema/COPD 0 Lung condition, other chronic condition 0 High blood pressure 0 High cholesterol 0 Kidney/Bladder condition incl. kidney stones 0 Liver condition 0 Gallstones 0 Anemia or other blood disorder 0 Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire 0 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?

- 0 Yes 0 No

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

- Beer: 0 None or less than 32 oz. 0 32 oz. or more Wine: 0 None or less than 18 oz. 0 18 oz. or more Hard: 0 None or less than 4 oz. 0 4 oz. or more

9. Within the last 12 months have you had any unexplained and/or undiagnosed symptoms, health problems, or medical concerns for which you have not yet seen a health care professional? Please check any items below that apply as well as listing any other symptoms or concerns on the line marked "other":

- 0 Fever 0 Rectal bleeding 0 Swollen glands 0 Loss of appetite 0 Chest pain 0 Dizziness 0 Shortness of breath 0 Chronic fatigue 0 Abdominal or pelvic pain 0 Rash 0 Loss of consciousness 0 Skin lesions 0 Unexplained weight loss 0 Lumps 0 Other 0 None of the above

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

- 0 Yes 0 No

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

- 0 Yes 0 No

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

12. Are you pregnant or an expectant father, or will you be providing medical insurance coverage for a newborn or new adoptee within the next 9 months?

- 0 Yes 0 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?

- 0 Yes 0 No

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

[] / [] / [] month day year

II. BILLING INFORMATION

The Subscriber 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

New account

Change from one plan design to another

3. For which plan would you like to apply?

Plan 20/20

Plan 750/1500

Plan 25/100

Plan 500/1000

Plan 1000/2000

4. Kaiser Permanente Medical Record Number:

5. Home Phone:

6. Work Phone:

For applicants using an insurance broker

7. Broker/General Agent Name:

8. Broker/General Agent ID:

I understand that the broker of record may receive monetary and/or nonmonetary payments from the Health Plan and/or Kaiser Permanente Insurance Company (KPIC) in connection with the purchase of this health plan coverage.

III. FAMILY TO BE COVERED

SUBSCRIBER: AN APPLICATION MUST BE COMPLETED FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE.

Relationship Name—Last First M.I. Date of Birth Sex (M/F) S.S.N.

Spouse _____

Child _____

Child _____

Child _____

Child _____

Child _____

Child _____

For Office Use Only:

PH CSC

AREA No. _____

MEDICAL RECORD No. _____ FAMILY ACCOUNT No. _____ PURCHASER No. _____

DATE RECEIVED _____ STATUS: APPROVED DENIED EFFECTIVE DATE _____

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

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 1-800-634-4579 before signing this application. Any person obligated for any part of a premium may cancel such an agreement within 72 hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to Kaiser Foundation Health Plan of Ohio or its agents or other representatives. Notice of cancellation is considered given when the prospective subscriber mails a letter to Kaiser Foundation Health Plan of Ohio.

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. You can choose to update your application information by telephone at 1-800-634-4579, by fax at 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.

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 of Ohio (or its delegee) 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 of Ohio for a period of up to 5 years preceding this application for membership in the Kaiser Permanente for Individuals and Families program. 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 program. I understand that Kaiser Foundation Health Plan of Ohio (or its delegee) 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 of Ohio (or its delegee), 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. REQUEST FOR PARTICIPATION IN OHIO TRUST FOR INDIVIDUAL DENTAL CARE SERVICES

NOTE TO APPLICANT: This application for membership in Kaiser Permanente for Individuals and Families also serves as your request for participation in the Ohio Trust for Individual Dental Care Services (the "Trust"), which is administered by Delta Dental Plan of Ohio pursuant to an arrangement between Kaiser Permanente and Delta Dental Plan of Ohio. If you are accepted as a member of Kaiser Permanente for Individuals and Families, you will also be accepted as a participant in the Trust. Participation in the Trust is not optional. All applicants accepted for membership in Kaiser Permanente for Individuals and Families will be enrolled automatically in the Trust and will receive dental benefits as a member under a group contract issued by Delta Dental Plan of Ohio to the Trust. If your membership in Kaiser Permanente for Individuals and Families terminates for any reason, your participation in the Trust and your dental benefits will also terminate. If the arrangement between Kaiser Permanente and Delta Dental of Ohio terminates, the Trust will be terminated and your participation in the Trust and your dental benefits will also terminate. You will receive a certificate of coverage issued by Delta Dental Plan of Ohio describing your dental benefits. The premium charged for enrollment in Kaiser Permanente for Individual and Families will include the premium for dental benefits under the group contract issued to the Trust by Delta Dental Plan of Ohio.

By signing below as the Applicant, I agree and affirm that: (1) I am requesting participation in the Ohio Trust for Individual Dental Care Services, as amended; (2) The Trust is the holder of a group contract for dental care services issued by Delta Dental Plan of Ohio and all claims for benefits under that group contract must be made to Delta Dental Plan of Ohio; (3) I will be bound by the terms and conditions of the certificate of coverage issued by Delta Dental Plan of Ohio to me; and (4) my participation in the Trust will continue until the earlier to occur of (i) termination of my membership in Kaiser Foundation Health Plan of Ohio under a contract for Kaiser Permanente for Individuals and Families, as it may be renamed; (ii) termination of the group contract issued by Delta Dental Plan of Ohio to the Trust; or (iii) termination of the Trust.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.)

Sign below to apply for membership and to affirm that all statements on this application are true.

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.

VII. HIPAA ELIGIBILITY QUESTIONNAIRE AND REQUEST FOR ENROLLMENT

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

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 five requirements listed below. Please complete this application page 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 a 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 guarantee to enroll you in the applicable Kaiser Permanente HIPAA-qualified plan only if you meet HIPAA eligibility requirements, and only if your Kaiser Permanente for Individuals and Families 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 Ohio), but HIPAA rates may be significantly higher than Kaiser Permanente for Individuals and Families rates. Information on your specific HIPAA plan rates is available by calling 1-800-524-7371 ext. 5613.

***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.

****Maryland residents:** You may be eligible for health coverage under the Maryland Health Insurance Plan (MHIP). MHIP is a high-risk pool for Maryland residents who are medically uninsurable. You may obtain more information regarding MHIP from the Maryland Health Insurance Plan, PO Box 47160, Baltimore, Maryland 21244-7160, 866-780-7105. Information regarding MHIP also may be obtained from the Maryland Insurance Administration Web site at www.mdinsurance.state.md.us.

*****Ohio residents:** You are responsible for choosing the HIPAA plan for which you would like to receive health coverage. As part of a state-mandated program, Kaiser Foundation Health Plan of Ohio offers two HIPAA plans: HIPAA Basic and HIPAA Standard. For a comparison of rates and benefits between the two HIPAA plans, please review the HIPAA section of the enrollment booklet.

If I qualify for HIPAA, please enroll me in: (please check one of the following plans)

- HIPAA Basic HIPAA Standard

QUESTIONNAIRE

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

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. (Refer to the *Disclosure Form* 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:

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| 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 HIPAA. | 0 Yes 0 No |
| ii. If I do not qualify for Kaiser Permanente for Individuals and Families and I do qualify for HIPAA, I request that I be enrolled in HIPAA. | 0 Yes 0 No |
| iii. If you answered "Yes" to the question above, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership. I have attached proof(s) of creditable coverage. | 0 Yes 0 No |

X	
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Signature

Date