

# Enrolling is Simple. Just Follow These 2 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: 800-915-0501 fax: 858-759-2661

## Step 2

**SEND THE COMPLETED APPLICATION TO:**

eKaiserinsurance.com  
6641 Calle Ponte Bella  
Rancho Santa Fe, CA 92091

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: 800-915-0501**

**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](http://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 \_\_\_\_\_  
 ( ) \_\_\_\_\_  Day  Evening  
 Home phone  
 ( ) \_\_\_\_\_  Day  Evening  
 Work phone \_\_\_\_\_  
 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:**

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you work for an employer who has from one to 50 employees who work 24 hours or more a week?</b>
If you answered No, you've picked the right health plan. If you answered Yes, please answer the following questions and read on.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will your employer receive a tax deduction for your health care coverage?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will your employer pay for your coverage or reimburse you for any portion of your premium?</b>

**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. For more information, please call **1-866-279-0704**.

## 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

5. If you or another family member does not qualify for the KPIF plan you selected but does qualify for another KPIF plan or rate, we need your instruction:

I am willing to accept enrollment in a plan with different rates or benefits from the one I originally selected. I will be notified of the plan I qualify for and given the option of canceling.

Yes  No

**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

**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

**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 in its decision-making based on: 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; age; or genetic information.

**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**

Stephen Masula

Agent name (please print) \_\_\_\_\_

471389

Agent ID # \_\_\_\_\_

6641 Calle Ponte Bella

Address \_\_\_\_\_

Rancho Santa Fe CA 92091

City State ZIP

800-915-0501 858-759-2661

Phone Fax

kaiser@ekaiserinsurance.com

E-mail address \_\_\_\_\_

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:

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

**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.**

**(This page is intentionally left blank.)**

**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

**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, or AIDS (acquired immune deficiency syndrome) (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-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

**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  
covercolorado@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 _____	

