KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for KPIF coverage, you must live in our Virginia service area.

Who should not use this application?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, you're not eligible for KPIF coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Health Insurance Marketplace at HealthCare.gov.
- If you're already a KPIF member, don't use this form. To make changes to your account, call **1-866-410-7536.**

Things to remember

- If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** to learn what proof you may need to submit – and when your plan effective date will be.
- Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- Remember, if you're enrolling in a new plan, that won't automatically cancel any other coverage you have. To avoid paying 2 premiums or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts.
- Please send back all pages of this application. **If your application is incomplete, not signed, doesn't include your first month's payment, or doesn't include required proof of your qualifying life event (if applicable), it may be canceled.** Send these by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-855-414-2796**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-670-5420.** For TTY, call **711.**
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call him or her for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Primary applicant

STEP 1: Tell us when you're applying

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose the life event that made you eligible for a special enrollment period (please choose only one):

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Health Insurance Marketplace
- ☐ Change in eligibility for a Health Reimbursement Account (HRA)

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Proof of eligibility is required. Please visit **kp.org/specialenrollment** or call **1-800-494-5314** for more information.

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review your membership records to check when and why you lost coverage.

STEP 2: Choose your health plan

Choose one health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze	Silver	Gold	Platinum
☐ KP VA Bronze 5500/50/Dental	☐ KP VA Silver 2500/35/Dental ☐ KP VA Silver 6000/40/Dental ☐ KP VA Silver 3200/20%/HSA/Dental	☐ KP VA Gold 1500/20/Dental ☐ KP VA Gold 1000/20/Dental ☐ KP VA Gold 0/20/Dental	☐ KP VA Platinum 0/10/Dental

Catastrophic plan

To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

☐ KP VA Catastrophic 8150/0/Dental

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement* and *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-777-7902,** or contact your broker.

STEP 3: Choose your optional adult dental plan

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. Preventive adult dental is also included for members 19 and older. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

- ☐ Yes. I'd like to enroll in the optional adult dental plan.
- ☐ No. I'm not interested in the optional adult dental coverage.

STEP 4: Enter your information

Primary applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

First name

Social Security number (if any)

Last name

Date of birth (mm/dd/yyyy)

MI

Former medical record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Phone

Home address (no P.O. boxes, please)

City

State

ZIP code

County

Billing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Applicants 18 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Parent or legal guardian (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English)

Preferred language read (if not English)

Spouse

First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Applicants 18 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. Yes No

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 18 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. Yes No

2 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 18 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. Yes No

3 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 18 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. Yes No

Primary applicant

STEP 5: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application only. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 3 dependents 18 and older signing, please attach a copy of this page with the additional signatures. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.
- **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 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED STATE LAW.**
- I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B.

X _____ Date (mm/dd/yyyy) __/__/____

Primary applicant (parent or legal guardian for children under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

Primary applicant

STEP 7: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options (choose one) ☐ Credit card ☐ Debit card ☐ Electronic payment ☐ Check ☐ Money order

If credit or debit card ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

If electronic payment ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's premium amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page one.

Primary applicant

Automatic monthly payments (optional)

This **optional** service allows you to automatically pay your monthly premiums electronically on the last day of the month (unless it falls on a weekend or holiday). If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-800-777-7902.**

Do you want to use your first month's payment method for your automatic payments?

☐ Yes (skip this page) ☐ No (fill out this page)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State ZIP code

Automatic payment options (choose one) ☐ Credit card (debit cards can't be used) ☐ Electronic payment

If credit card ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

If electronic payment ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

For applicants using an agent/broker/KPIF representative

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. A Kaiser Permanente representative includes any agent/broker/KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/Broker/KPIF representative first name

MI

Last name

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.
Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.
I (the applicant) authorize the insurance agent/broker/KPIF representative listed below to share enrollment and disenrollment information specific to this application with Kaiser Permanente.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

To be completed by your Kaiser Permanente–appointed agent/broker/KPIF representative after completion of this application:

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation. ☐ Yes ☐ No

X

Agent/Broker/KPIF representative

Date (mm/dd/yyyy)

Agent/Broker (first, middle, last) (please print)

Address

City

State

ZIP code

National producer number (NPN)

Phone

Fax

Kaiser Permanente–appointed broker ID

Firm name

Firm ID number

General agency name

General agency ID number

Broker firm's federal tax ID number

General agency's federal tax ID number

Email address

KPIF representative (first, middle, last) (please print)

KPIF representative's license number

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

KAISER PERMANENTE®