Application for health coverage

Who can use this application?

You may use this form to apply for individual or family coverage provided by Kaiser Permanente for Individuals and Families (KPIF) Kaiser Foundation Health Plan of Georgia, Inc.

- You must reside in our Georgia KPIF service area.
- If you want coverage for your family on the same KPIF plan, please complete one application for your entire family.
- If a family member wants a different health plan, he or she must complete a separate application.
- If a family member wishes to confidentially complete an application, he or she may either request additional forms or use a photocopy of this application.

If you qualify for financial assistance (federal help paying copayments, coinsurance, deductible, or premiums), do not complete this form. You must apply for coverage through Health Insurance Marketplace in Georgia at **healthcare.gov**. If you qualify, the federal government will pay any financial assistance to Kaiser Permanente on your behalf.

Apply faster online

- You can apply faster online at **buykp.org/apply**.
- If you would like to communicate with us electronically, please apply online and set up a secure email account.
- If you're working with a broker, contact him or her for assistance. He or she will be happy to walk you through the plan selection and application process.

Application instructions

- Please answer all questions and type or print using ink only.
- Complete the "Tell Us About Yourself" section in Step 3 if you are applying for KPIF coverage as an individual. If your application is for child-only enrollment, the child's information should be entered in the "Tell Us About Yourself" section in Step 3.
- Complete Step 3 for each additional family member applying for the same plan.
- All applications must be accompanied by payment for the first month's premium. Please make certain that you have provided the necessary information in Step 7.
- Completed applications received with payment by the 15th of the month will be effective on the first of the next month. Completed applications received with payment on the 16th of the month or later will be effective on the first of the month after the next.
- Make sure that your application is complete, signed, and includes your first month's premium payment. If your application is incomplete, it may delay your enrollment effective date.
- If you do not include payment for your first month's premium, your application may be delayed and/or canceled.
- If any signature or information is missing in Step 9 (agent/broker/KPIF representative information), your application will be considered incomplete.
- Send your complete, signed application and payment by mail or fax:

  Mail your signed application to:
  Kaiser Permanente
  California Service Center KPIF
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to:
  Kaiser Permanente for Individuals and Families **1-866-816-5139**

Need help with this application?

- For assistance completing the application, please call **1-800-494-5314**.
- If you are working with a broker, please call him or her for assistance.
- We will provide language assistance at no cost to you.

Step 1

Please complete the following information. If any family members are applying for coverage under different plans, please submit a separate application form for each plan.

HEALTH PLANS

Choose one KPIF health plan.

Bronze	Silver	Gold
☐ KP GA Bronze 5000/50	☐ KP GA Silver 1500/30	☐ KP GA Gold 0/20
☐ KP GA Bronze 4500/50/HSA	☐ KP GA Silver 2500/30	☐ KP GA Gold 1000/20
☐ KP GA Bronze 5000/30%/HSA	☐ KP GA Silver 1750/25%/HSA	

CATASTROPHIC PLAN

We also offer a Catastrophic plan, a high-deductible plan option for applicants under age 30 and certain persons age 30 and older. If you or any family members are age 30 or older, each person may only apply for this plan if you submit with your completed application a certificate of exemption from Health Insurance Marketplace in Georgia for each person that indicates lack of affordable coverage or hardship.

☐ KP GA Catastrophic 6350/0

For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Evidence of Coverage* for a particular plan, please call us at **1-800-634-4579** or contact your broker.

Step 2

All our health plans provide essential health benefits, including pediatric dental. You may decline this coverage only if you are covered by another pediatric dental plan. All applicants must complete the "Pediatric Dental Plan" section.

PEDIATRIC DENTAL PLAN

We are required to include pediatric dental benefits with your health plan(s). By enrolling in a Kaiser Permanente Individuals and Families plan, you will also be enrolled in a separate pediatric dental plan underwritten by Delta Dental Insurance Company, unless you confirm (below) that you have purchased other pediatric dental coverage that has been certified by Health Insurance Marketplace in Georgia. We will rely on your confirmation, and we may take legal action, including, but not limited to, canceling your coverage should we determine that you did not have pediatric dental coverage as you represented. Failure to make an election will cause us to return the application.

☐ Enroll me in the Delta Dental pediatric dental plan along with the KPIF plan that I have chosen. I authorize Kaiser Foundation Health Plan of Georgia, Inc., to share my application information with Delta Dental Insurance Company to facilitate my enrollment in the pediatric dental plan. I understand that I will pay Delta Dental directly and failure to pay premiums may be considered a reason for termination of my coverage.

☐ I have purchased other pediatric dental coverage that has been certified by Health Insurance Marketplace in Georgia.

Step 3

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. Complete the rest of Step 3 for your family members.

If this application is for a child under the age of 18, the child is the primary applicant. For additional children covered on the same KPIF plan, complete the "Family Member(s) to be Covered" section on page 4.

Every person age 21 or older who is applying for coverage must indicate whether he or she has used tobacco four times or more per week in the last six months (except for religious or ceremonial purposes). Tobacco products include cigarettes, pipes, cigars, as well as snuff and chewing or other smokeless tobacco. Regular tobacco users will pay different premiums.

TELL US ABOUT YOURSELF (primary applicant)

Primary applicant or child-only applicant name (last, first, middle)			Health record number (if any)
Street address (no P.O. boxes please)			Apt. #
City	State	ZIP	County
Phone ( ) –	Other phone ( ) –		
Preferred language spoken (if not English)	Preferred language read (if not English)		
Social Security number	Date of birth (mm/dd/yyyy)		Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier: Dates of coverage:

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

FAMILY MEMBER(S) TO BE COVERED

All members must reside in our Georgia service area.

SPOUSE/DOMESTIC PARTNER

Name (last, first, middle)		Health record number (if any)
Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier: Dates of coverage:

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

(continues on next page)

Step 3 *(continued)*

Please complete the information below for each child covered under your plan. If you need space for additional applicants, attach another application and complete just the information for those applicants.

FAMILY MEMBER(S) TO BE COVERED

DEPENDENT 1

Name (last, first, middle)		Health record number (if any)
Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier**:** Dates of coverage**:**

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

DEPENDENT 2

Name (last, first, middle)		Health record number (if any)
Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier**:** Dates of coverage**:**

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

DEPENDENT 3

Name (last, first, middle)		Health record number (if any)
Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier**:** Dates of coverage**:**

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

DEPENDENT 4

Name (last, first, middle)		Health record number (if any)
Social Security number	Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Have you previously had insurance coverage? ☐ Yes ☐ No

If Yes, most recent insurance carrier**:** Dates of coverage**:**

For applicants age 21 or older: Have you used tobacco an average of four or more times per week in the past six months? ☐ Yes ☐ No

Step 4

If the primary applicant is a child under the age of 18, a parent or legal guardian should complete Step 4.

FINANCIALLY RESPONSIBLE PARTY (parent or legal guardian)

If the financially responsible party is someone other than the primary applicant, please complete the information below.

Name (last, first, middle)

Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Same address as primary applicant ☐ Yes ☐ No If No, fill in your address below.

Street address			Apt. #
City	State	ZIP	County
Phone ( ) –	Other phone ( ) –		
Preferred language spoken (if not English)	Preferred language read (if not English)		

Step 5

If you would like another person to act as your authorized representative, please complete Step 5.

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

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

Name of authorized representative (last, first, middle)

Street address		Apt. #
City	State	ZIP
Phone ( ) –		

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on matters related to this application.

Primary applicant or financially responsible party (parent or legal guardian for applicants under age 18)	Date (mm/dd/yyyy)
X	

Step 6

All applicants and dependents age 18 or older must read and sign below. If the primary applicant is younger than 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, copayments, coinsurance, and deductibles for all the applicants listed on this form.

APPLICATION AGREEMENT

All faxed and mailed correspondence must be signed and dated by the applicant or someone legally authorized to act on his or her behalf. The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **1-800-634-4579**.

Important: Required signatures — all applicants age 18 or over must sign and date below on the appropriate signature line. A parent or legal guardian must sign for all family members under the age of 18. If signatures are missing, we cannot continue processing the application.

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law.
- I know that under federal and state law, discrimination isn't permitted on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

Primary applicant or financially responsible party (parent or legal guardian for applicants under age 18) **X**	Date (mm/dd/yyyy)
Spouse/Domestic Partner **X**	Date (mm/dd/yyyy)
Dependent (age 18 or older) / Parent or Legal Guardian **X**	Date (mm/dd/yyyy)
Dependent (age 18 or older) / Parent or Legal Guardian **X**	Date (mm/dd/yyyy)
Dependent (age 18 or older) / Parent or Legal Guardian **X**	Date (mm/dd/yyyy)
Dependent (age 18 or older) / Parent or Legal Guardian **X**	Date (mm/dd/yyyy)

Step 7

Your application must be accompanied by payment information for your first month's premium. If your payment information is missing or incomplete, your application may be delayed and/or canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Do not send cash through the mail.

FIRST MONTH'S PREMIUM BILLING INFORMATION

Complete the following information for the financially responsible party. (The financially responsible party is the person who is the account holder on the bank account or credit/debit card.)

Name of financially responsible party (last, first, middle)	Payment amount for your first month's premium $	
Street address		Apt. #
City	State	ZIP

FIRST MONTH'S PREMIUM PAYMENT OPTIONS

Check your preferred payment option below and complete that section. Items returned by your financial institution are subject to a $25 processing fee.

☐ CREDIT/DEBIT CARD

Credit/Debit card information: ☐ Credit ☐ Debit ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's name as it appears on card

Credit/Debit card number	Expiration date (mm/yyyy)
Cardholder signature X	Date (mm/dd/yyyy)

☐ ELECTRONIC PAYMENT

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

Please debit: ☐ Checking account ☐ Savings account

Routing #	Account #

(At the bottom of your check, you will see three groups of numbers. The first group of numbers is your routing number; the second group is your account number.)

Account holder's full name (print)	Account holder signature X

☐ CHECK ☐ MONEY ORDER

- Make the check or money order payable to Kaiser Permanente for Individuals and Families.
- Write the name of the primary applicant on the check.
- Mail to the address listed on page 1.

Step 8

You can choose automatic monthly payments. Recurring automatic monthly payment is an optional service offered by Kaiser Permanente that allows members to automatically pay their monthly premium payment electronically.

AUTOMATIC MONTHLY PAYMENT BILLING INFORMATION

Same billing information as first month's premium? ☐ Yes ☐ No If no, complete the following information for the financially responsible party.

Name of financially responsible party (last, first, middle)

Street address		Apt. #
City	State	ZIP

AUTOMATIC MONTHLY PAYMENT OPTIONS

Check your preferred automatic monthly payment option below and complete that section.

I understand that if I have chosen the option to set up a recurring premium payment schedule with Online Resources Corporation (ORCC) and later wish to cancel or update that schedule, I must do either of the following:

1. Go to the following website: **kp.org/payonline** and follow instructions to create a profile and cancel or update my recurring payment schedule.
2. Call the KFHP Member Service Call Center at **1-866-278-9502** to obtain assistance from a customer service representative to cancel or update my recurring payment schedule.

☐ DEDUCT MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on the first day of each month and agree to the terms outlined above.

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

Please debit: ☐ Checking account ☐ Savings account

Routing #	Account #

(At the bottom of your check, you will see three groups of numbers. The first group of numbers is your routing number; the second group is your account number.)

Account holder's full name (print)	Account holder signature X

☐ DEDUCT MY CREDIT/DEBIT CARD

By filling out this section, you are requesting that your premiums be automatically deducted from your credit card on the first day of each month, and agreeing to the terms outlined above.

Credit/Debit card information: ☐ Credit ☐ Debit ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's name as it appears on card

Credit/Debit card number	Expiration date (mm/yyyy)
Cardholder signature X	Date (mm/dd/yyyy)

☐ I AM NOT INTERESTED IN THE AUTOMATIC MONTHLY PAYMENT OPTION

By selecting this option, you will automatically receive a monthly invoice from Kaiser Permanente for Individuals and Families.

Step 9

If you used an insurance agent or broker or a Kaiser Permanente for Individuals and Families (KPIF) representative, please make sure he or she completes this page.

FOR APPLICANTS USING AN AGENT/BROKER/KPIF REPRESENTATIVE

A Kaiser Permanente representative includes any KPIF representative who has provided you with assistance.

Agent/Broker/KPIF representative (last, first, middle)

Masula, Stephen - eKaiserinsurance.com

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.

AGENT, BROKER, AND KPIF REPRESENTATIVE INFORMATION

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

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

Masula, Stephen - eKaiserinsurance.com

Kaiser Permanente–appointed broker identification number

UAO

Street address		Apt. #
2235 Sara Way		
City	**State**	**ZIP**
Carlsbad	CA	92008

Phone	Fax
(800) 915 _ 0501	(888) 436 _ 4342

Email address

smasula@ekaiserinsurance.com