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).

- You must reside in our Hawaii service area.
- If you want coverage for your family on the same KPIF plan, please complete one application for the 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 Hawai`i Health Connector at hawaiihealthconnector.com. 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.

Application instructions

- Please answer all questions and type or print using ink only.
- Complete the "Tell Us About Yourself" section in Step 4 if you are applying for KPIF coverage as an individual. If you are applying for family coverage on the same KPIF plan, complete the "Tell Us About Yourself" section and the rest of Step 4 for your family members.
- If the primary applicant is a child under the age of 18, complete the "Tell Us About Yourself" section in Step 4. For additional children covered on the same KPIF plan, complete the "Family Member(s) to be Covered" section on page 4.
- 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 and signed. 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
  PO Box 23219, San Diego, CA 92193-9921]

  Or send it by secure fax to:
  Kaiser Permanente for Individuals and Families **1-866-920-6470**

Need help with this application?

- For assistance completing the application, please call **1-800-823-7423**.
- **We will provide language assistance at no cost to you.**
- If you are working with a broker, please call him or her for assistance.

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	Platinum
☐ KP Bronze Be Fit 50	☐ KP Silver II Be Fit 30	☐ KP Gold I Be Fit 20 ☐ KP Gold II Be Fit 20	☐ KP Platinum Be Fit 10

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, premiums, and dental plans, please review the details in your enrollment materials. To request a copy of the *Medical and Hospital Service Agreement* for a particular plan, please call us at **1-800-634-4579** or contact your broker.

Step 2

All of these 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 be offered and enrolled in a separate pediatric dental plan, unless you confirm (below) that you have purchased other pediatric dental coverage that has been certified by Hawai`i Health Connector. 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.

☐ Enroll me in the pediatric dental plan along with the KPIF plan that I have chosen.

☐ I have purchased other pediatric dental coverage that has been certified by the Hawai'i Health Connector.

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.

If you are applying for family coverage, complete the rest of Step 4 for your family members. If you or any family members are currently or have been Kaiser Permanente members, please include health record number(s) where indicated.

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 higher premiums.

TELL US ABOUT YOURSELF (primary 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

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

Have you previously had insurance coverage? ☐ Yes ☐ No

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

FAMILY MEMBER(S) TO BE COVERED

All members must reside in our Hawaii 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

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

Has your spouse/domestic partner previously had insurance coverage? ☐ Yes ☐ No

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

(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

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

Has this dependent previously had insurance coverage? ☐ Yes ☐ No

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

DEPENDENT 2

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

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

Has this dependent previously had insurance coverage? ☐ Yes ☐ No

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

DEPENDENT 3

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

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

Has this dependent previously had insurance coverage? ☐ Yes ☐ No

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

DEPENDENT 4

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

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

Has this dependent previously had insurance coverage? ☐ Yes ☐ No

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

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)

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

Street address	Apt. #

City	State	ZIP	County

Phone	Other phone
( ) –	( ) –

Relationship to applicant ☐ Parent/Legal guardian ☐ Spouse/Domestic partner ☐ Other:

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 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.
- We may rescind coverage if the applicant (or person seeking coverage on behalf of the applicant) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. Making an intentional misrepresentation of material fact includes intentionally providing incomplete or incorrect information about any person applying for coverage on this application, and such information was the basis for our decision to accept his or her family member for coverage. Rescinding coverage means completely voiding the member's contract of coverage as if no coverage had ever existed. Once we decide to rescind coverage, we will send the applicant a written notice at least 30 days before we actually rescind, explaining the basis for our decision and how the applicant can appeal it. Once coverage is rescinded, the applicant will be required to pay for any services we may have covered. But the applicant would also be entitled to a refund of any premiums paid. This means that premiums refunded would be reduced by any amounts the applicant owed for any covered services received.

On behalf of myself and as authorized agent for all persons named in this application and for related family members, I certify the information provided here is true and complete, and that we agree to abide by the terms of coverage in Kaiser Permanente's nongroup *Medical and Hospital Service Agreement*.

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) **X**	Date (mm/dd/yyyy)

ARBITRATION AGREEMENT

Kaiser Foundation Health Plan Arbitration Agreement:

Applicant understands and agrees that, except for certain situations described in Kaiser Permanente's nongroup *Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to the *Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be decided by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. A complete description of the arbitration provision is contained in Kaiser Permanente's nongroup *Medical and Hospital Service Agreement*.

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) **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.

KAISER PERMANENTE®

Primary applicant _____

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 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. We will not consider your application to be complete until your broker completes this section.

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

165564

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

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

Email address

kaiser@ekaiserinsurance.com