Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.342.1612

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

Kaiser Permanente for Individuals and Families Membership Application

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 about your current or past health can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 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 our Member Service Call Center toll free at 1-800-464-4000 to request assistance completing this questionnaire.** Kaiser Permanente does not discriminate based upon: 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; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

I. Each person in the family must complete a separate application for membership.

A. Height (without shoes) _____ Ft. _____ In. Weight (dressed) _____ Lbs.

B. 0 Male 0 Female

C. 0 Single 0 Married 0 Domestic partner (Please refer to *DF/EOC* for eligibility.)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name _____ First name _____

Previous medical record number _____

E. Membership application for:

Last name _____

0 Mr. 0 Mrs. 0 Miss 0 Ms. First name _____ MI _____

F. Date of birth _____

1. **How many times have you been hospitalized in the last 12 months, except for pregnancy?**
   0 Never 0 2 times
   0 1 time 0 3 or more times

2. **How many times have you required medical attention in the last 12 months, except for pregnancy?**
   0 0–2 times 0 6–8 times
   0 3–5 times 0 9 or more times

3. **Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?**
   0 Yes 0 No

4. **(a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?**
   0 ½ pack or less 0 2 or more packs
   0 1 pack 0 N/A
   0 1½ packs
   (b) For how long?
   0 9 years or less 0 20–29 years
   0 10–14 years 0 Over 30 years
   0 15–19 years 0 N/A

5. **In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?**
   0 Yes 0 No

6. **In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?**
   0 Yes 0 No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(Health questionnaire continues on page 2.)

I. Each person in the family must complete a separate application for membership. *(continued)*

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (*please check **all** that apply*):

- O AIDS, ARC
- O Sexually transmitted diseases
- O Hepatitis
- O Hernia not repaired/ GI reflux
- O Back/Neck pain or injury
- O Bone marrow transplant
- O Crohn's or ulcerative colitis
- O Depression or anxiety
- O Mental health condition
- O Eating disorder, anorexia nervosa/bulimia
- O Heart or valve condition
- O Asthma
- O Emphysema/COPD
- O Lung condition, other chronic condition
- O High blood pressure
- O High cholesterol
- O Kidney/Bladder condition incl. kidney stones
- O Liver condition
- O Gallstones
- O Anemia or other blood disorder
- O Ulcer
- O Painful menstrual cycle or female reproductive disorder
- O Lupus/SLE
- O Silicone breast implants
- O Melanoma/ Breast/Prostate/ Bladder cancer
- O Skin cancer
- O Other cancers
- O Aneurysm
- O MS/ALS/ Parkinson's/ Alzheimer's
- O Neurologic condition
- O Pacemaker
- O Prostate condition
- O Rheumatoid arthritis
- O Seizures
- O Sickle cell anemia
- O Diabetes
- O Stomach or intestinal problems
- O Stroke
- O Lumps

O Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____

_____

O **None of the above**

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

O Yes O No

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

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

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- O Fever
- O Swollen glands
- O Chest pain
- O Shortness of breath
- O Abdominal or pelvic pain
- O Loss of consciousness
- O Unexplained weight loss
- O Rectal bleeding
- O Loss of appetite
- O Dizziness
- O Chronic fatigue
- O Rash
- O Skin lesions
- O Lumps
- O Chronic pain (if Yes, please explain): _____

_____

O **None of the above**

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication here: _____

_____

_____

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

O Yes O No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

O Yes O No

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

[ ] / [ ] / [ ]
Month Day Year

Please review the health questionnaire to be sure you have answered all questions, 1–13.

II. Billing information (head of household only)

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

First name MI

0 Mr. 0 Mrs.
0 Miss 0 Ms.

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City State ZIP code

2. Account information
- 0 Addition of a family member to an existing account
- 0 Switching coverage from an existing account
- 0 New account

3. For which plan would you like to apply?
- 0 $1,500 Deductible Plan
- 0 $1,000 Deductible Plan
- 0 $500 Deductible Plan
- 0 $50 Copayment Plan
- 0 $25 Copayment Plan
- 0 $30/$2,700 Deductible Plan with HSA
- 0 $0/$2,700 Deductible Plan with HSA
- 0 $0/$1,500 Deductible Plan with HSA

4. Are you applying for the optional dental plan?

0 No 0 Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente medical record number

6. Home phone

7. Work phone

8. Primary language:
- 0 English
- 0 Other_____

For Applicants using an insurance broker:

9. Broker name

HEALTH PLAN ONE

10. Broker ID

20953

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

III. Family to be covered (other than head of household) Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse						
Child						
Child						
Child						
Child						
Child						

All Applicants: Please read the following information prior to signing 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.

IV. 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 will be based primarily on health information you provide in your application and during the enrollment process. If you are unsure of your current medical status, 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 prior to making our decision. We may review your use of health care services for up to a year following your KPIF enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KPIF enrollment.

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 determine that you or someone on your behalf intentionally gave us incomplete or incorrect material information about your current or past health in your application or during the enrollment process, and our decision to accept your enrollment was based, in whole or in part, on the misinformation, we will rescind your membership (completely void your membership so that no coverage ever existed). You will be required to pay as a nonmember for any services we provided or covered. Please refer to the *Disclosure Form* for more information about rescission of membership.

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**

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 black ink only**.

V. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for small claims court cases) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Disclosure Form and Evidence of Coverage.*

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**

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 black ink only**.

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_____

VI. 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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]).** 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 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 coverage.

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 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 Medical Information, HIV/AIDS- or ARC-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 thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claimfor benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy ofthis 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.

(continues)

VI. Authorization to Obtain or Release Medical Information *(continued)*

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 are 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**

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 black ink only**.

VII. HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in Section A of the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families (KPIF) coverage but meet **all** of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the KPIF plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements, and only if your KPIF application is declined. If you qualify for both plans, we will enroll you in KPIF. Both plans will have the same benefits, but HIPAA rates may be significantly higher than KPIF rates. For information about your specific HIPAA plan rates, please call 1-800-464-4000.

Questionnaire

Please read Section A, then complete either Section B or Section C (but not both).

A. Please read the following HIPAA requirements and determine whether all five are true statements.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
2. My most recent health care coverage was through a group health plan, a governmental plan, or a church plan.
3. I have both elected and exhausted all continuation health care coverage available under federal (COBRA) and state continuation coverage laws.
4. I do not currently have other health care coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was **not** terminated for fraud or failure to pay premiums.

B. If all five statements are true, please instruct Kaiser Permanente whether you wish to enroll in a HIPAA plan in the event you do not qualify for KPIF by checking either Yes or No below:

- If I do not qualify for KPIF and I do qualify for HIPAA, I request that I be enrolled in HIPAA. 0 **Yes** 0 **No**

If you checked Yes, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership in HIPAA.

C. If any of these five statements is not true, please indicate your understanding that you do not qualify for HIPAA by checking Yes below:

- I understand that I do not qualify for HIPAA. 0 **Yes**

X _____

Signature **Date**

Use black ink only.

Kaiser Permanente for Individuals and Families Membership Application

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 about your current or past health can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 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 our Member Service Call Center toll free at 1-800-464-4000 to request assistance completing this questionnaire.** Kaiser Permanente does not discriminate based upon: 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; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

I. Each person in the family must complete a separate application for membership.

A. Height (without shoes) _____ Ft. _____ In. Weight (dressed) _____ Lbs.

B. 0 Male 0 Female

C. 0 Single 0 Married 0 Domestic partner (Please refer to *DF/EOC* for eligibility.)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name _____ First name _____

Previous medical record number _____

E. Membership application for:

Last name _____

0 Mr. 0 Mrs. 0 Miss 0 Ms. First name _____ MI _____

F. Date of birth _____

1. **How many times have you been hospitalized in the last 12 months, except for pregnancy?**
   0 Never 0 2 times
   0 1 time 0 3 or more times

2. **How many times have you required medical attention in the last 12 months, except for pregnancy?**
   0 0–2 times 0 6–8 times
   0 3–5 times 0 9 or more times

3. **Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?**
   0 Yes 0 No

4. **(a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?**
   0 ½ pack or less 0 2 or more packs
   0 1 pack 0 N/A
   0 1½ packs
   (b) For how long?
   0 9 years or less 0 20–29 years
   0 10–14 years 0 Over 30 years
   0 15–19 years 0 N/A

5. **In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?**
   0 Yes 0 No

6. **In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?**
   0 Yes 0 No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(Health questionnaire continues on page 2.)

I. Each person in the family must complete a separate application for membership. *(continued)*

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (*please check **all** that apply*):

- O AIDS, ARC
- O Sexually transmitted diseases
- O Hepatitis
- O Hernia not repaired/ GI reflux
- O Back/Neck pain or injury
- O Bone marrow transplant
- O Crohn's or ulcerative colitis
- O Depression or anxiety
- O Mental health condition
- O Eating disorder, anorexia nervosa/bulimia
- O Heart or valve condition
- O Asthma
- O Emphysema/COPD
- O Lung condition, other chronic condition
- O High blood pressure
- O High cholesterol
- O Kidney/Bladder condition incl. kidney stones
- O Liver condition
- O Gallstones
- O Anemia or other blood disorder
- O Ulcer
- O Painful menstrual cycle or female reproductive disorder
- O Lupus/SLE
- O Silicone breast implants
- O Melanoma/ Breast/Prostate/ Bladder cancer
- O Skin cancer
- O Other cancers
- O Aneurysm
- O MS/ALS/ Parkinson's/ Alzheimer's
- O Neurologic condition
- O Pacemaker
- O Prostate condition
- O Rheumatoid arthritis
- O Seizures
- O Sickle cell anemia
- O Diabetes
- O Stomach or intestinal problems
- O Stroke
- O Lumps

O Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____

_____

O **None of the above**

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

O Yes O No

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

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

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- O Fever
- O Swollen glands
- O Chest pain
- O Shortness of breath
- O Abdominal or pelvic pain
- O Loss of consciousness
- O Unexplained weight loss
- O Rectal bleeding
- O Loss of appetite
- O Dizziness
- O Chronic fatigue
- O Rash
- O Skin lesions
- O Lumps

O Chronic pain (if Yes, please explain): _____

_____

O **None of the above**

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication here: _____

_____

_____

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

O Yes O No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

O Yes O No

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

[ ] / [ ] / [ ]
Month Day Year

Please review the health questionnaire to be sure you have answered all questions, 1–13.

II. Billing information (head of household only)

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

First name MI

0 Mr. 0 Mrs.
0 Miss 0 Ms.

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City State ZIP code

2. Account information
- 0 Addition of a family member to an existing account
- 0 Switching coverage from an existing account
- 0 New account

3. For which plan would you like to apply?
- 0 $1,500 Deductible Plan
- 0 $1,000 Deductible Plan
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- 0 $50 Copayment Plan
- 0 $25 Copayment Plan
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0 No 0 Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente medical record number

6. Home phone

7. Work phone

8. Primary language:
- 0 English
- 0 Other_____

For Applicants using an insurance broker:

9. Broker name

HEALTH PLAN ONE

10. Broker ID

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

III. Family to be covered (other than head of household) Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse						
Child						
Child						
Child						
Child						
Child						

All Applicants: Please read the following information prior to signing below.

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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**

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 black ink only**.

V. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for small claims court cases) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Disclosure Form and Evidence of Coverage.*

X _____ **Applicant/Head of household**	**Today's date**
X _____ **Applicant's spouse**	**Today's date**
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MEDICAL RECORD NO. _____	FAMILY ACCOUNT NO. _____	PURCHASER NO._____
DATE RECEIVED _____	STATUS: 0 APPROVED 0 DENIED	EFFECTIVE DATE_____

VI. 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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]).** 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 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 coverage.

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 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 Medical Information, HIV/AIDS- or ARC-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 thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claimfor benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy ofthis 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.

(continues)

VI. Authorization to Obtain or Release Medical Information *(continued)*

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 are 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**

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 black ink only**.

VII. HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in Section A of the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families (KPIF) coverage but meet **all** of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the KPIF plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements, and only if your KPIF application is declined. If you qualify for both plans, we will enroll you in KPIF. Both plans will have the same benefits, but HIPAA rates may be significantly higher than KPIF rates. For information about your specific HIPAA plan rates, please call 1-800-464-4000.

Questionnaire

Please read Section A, then complete either Section B or Section C (but not both).

A. Please read the following HIPAA requirements and determine whether all five are true statements.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
2. My most recent health care coverage was through a group health plan, a governmental plan, or a church plan.
3. I have both elected and exhausted all continuation health care coverage available under federal (COBRA) and state continuation coverage laws.
4. I do not currently have other health care coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was **not** terminated for fraud or failure to pay premiums.

B. If all five statements are true, please instruct Kaiser Permanente whether you wish to enroll in a HIPAA plan in the event you do not qualify for KPIF by checking either Yes or No below:

- If I do not qualify for KPIF and I do qualify for HIPAA, I request that I be enrolled in HIPAA. 0 **Yes** 0 **No**

If you checked Yes, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership in HIPAA.

C. If any of these five statements is not true, please indicate your understanding that you do not qualify for HIPAA by checking Yes below:

- I understand that I do not qualify for HIPAA. 0 **Yes**

X _____

Signature **Date**

Use black ink only.

Kaiser Permanente for Individuals and Families Membership Application

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 about your current or past health can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 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 our Member Service Call Center toll free at 1-800-464-4000 to request assistance completing this questionnaire.** Kaiser Permanente does not discriminate based upon: 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; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

I. Each person in the family must complete a separate application for membership.

A. Height (without shoes) _____ Ft. _____ In. Weight (dressed) _____ Lbs.

B. 0 Male 0 Female

C. 0 Single 0 Married 0 Domestic partner (Please refer to *DF/EOC* for eligibility.)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name _____ First name _____

Previous medical record number _____

E. Membership application for:

Last name _____

0 Mr. 0 Mrs. 0 Miss 0 Ms. First name _____ MI _____

F. Date of birth _____

1. **How many times have you been hospitalized in the last 12 months, except for pregnancy?**
   0 Never 0 2 times
   0 1 time 0 3 or more times

2. **How many times have you required medical attention in the last 12 months, except for pregnancy?**
   0 0–2 times 0 6–8 times
   0 3–5 times 0 9 or more times

3. **Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?**
   0 Yes 0 No

4. **(a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?**
   0 ½ pack or less 0 2 or more packs
   0 1 pack 0 N/A
   0 1½ packs
   (b) For how long?
   0 9 years or less 0 20–29 years
   0 10–14 years 0 Over 30 years
   0 15–19 years 0 N/A

5. **In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?**
   0 Yes 0 No

6. **In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?**
   0 Yes 0 No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(Health questionnaire continues on page 2.)

I. Each person in the family must complete a separate application for membership. *(continued)*

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (*please check **all** that apply*):

- O AIDS, ARC
- O Sexually transmitted diseases
- O Hepatitis
- O Hernia not repaired/ GI reflux
- O Back/Neck pain or injury
- O Bone marrow transplant
- O Crohn's or ulcerative colitis
- O Depression or anxiety
- O Mental health condition
- O Eating disorder, anorexia nervosa/bulimia
- O Heart or valve condition
- O Asthma
- O Emphysema/COPD
- O Lung condition, other chronic condition
- O High blood pressure
- O High cholesterol
- O Kidney/Bladder condition incl. kidney stones
- O Liver condition
- O Gallstones
- O Anemia or other blood disorder
- O Ulcer
- O Painful menstrual cycle or female reproductive disorder
- O Lupus/SLE
- O Silicone breast implants
- O Melanoma/ Breast/Prostate/ Bladder cancer
- O Skin cancer
- O Other cancers
- O Aneurysm
- O MS/ALS/ Parkinson's/ Alzheimer's
- O Neurologic condition
- O Pacemaker
- O Prostate condition
- O Rheumatoid arthritis
- O Seizures
- O Sickle cell anemia
- O Diabetes
- O Stomach or intestinal problems
- O Stroke
- O Lumps

O Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____

_____

O **None of the above**

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

O Yes O No

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

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

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- O Fever
- O Swollen glands
- O Chest pain
- O Shortness of breath
- O Abdominal or pelvic pain
- O Loss of consciousness
- O Unexplained weight loss
- O Rectal bleeding
- O Loss of appetite
- O Dizziness
- O Chronic fatigue
- O Rash
- O Skin lesions
- O Lumps

O Chronic pain (if Yes, please explain): _____

_____

O **None of the above**

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication here: _____

_____

_____

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

O Yes O No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

O Yes O No

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

[ ] / [ ] / [ ]
Month Day Year

Please review the health questionnaire to be sure you have answered all questions, 1–13.

II. Billing information (head of household only)

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

First name MI

0 Mr. 0 Mrs.
0 Miss 0 Ms.

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City State ZIP code

2. Account information
- 0 Addition of a family member to an existing account
- 0 Switching coverage from an existing account
- 0 New account

3. For which plan would you like to apply?
- 0 $1,500 Deductible Plan
- 0 $1,000 Deductible Plan
- 0 $500 Deductible Plan
- 0 $50 Copayment Plan
- 0 $25 Copayment Plan
- 0 $30/$2,700 Deductible Plan with HSA
- 0 $0/$2,700 Deductible Plan with HSA
- 0 $0/$1,500 Deductible Plan with HSA

4. Are you applying for the optional dental plan?

0 No 0 Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente medical record number

6. Home phone

7. Work phone

8. Primary language:
- 0 English
- 0 Other_____

For Applicants using an insurance broker:

9. Broker name

HEALTH PLAN ONE

10. Broker ID

20953

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

III. Family to be covered (other than head of household) Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse						
Child						
Child						
Child						
Child						
Child						

All Applicants: Please read the following information prior to signing 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.

IV. 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 will be based primarily on health information you provide in your application and during the enrollment process. If you are unsure of your current medical status, 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 prior to making our decision. We may review your use of health care services for up to a year following your KPIF enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KPIF enrollment.

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 determine that you or someone on your behalf intentionally gave us incomplete or incorrect material information about your current or past health in your application or during the enrollment process, and our decision to accept your enrollment was based, in whole or in part, on the misinformation, we will rescind your membership (completely void your membership so that no coverage ever existed). You will be required to pay as a nonmember for any services we provided or covered. Please refer to the *Disclosure Form* for more information about rescission of membership.

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**

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 black ink only**.

V. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for small claims court cases) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Disclosure Form and Evidence of Coverage.*

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**

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 black ink only**.

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_____

VI. 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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]).** 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 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 coverage.

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 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 Medical Information, HIV/AIDS- or ARC-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 thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claimfor benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy ofthis 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.

(continues)

VI. Authorization to Obtain or Release Medical Information *(continued)*

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 are 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**

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 black ink only**.

VII. HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in Section A of the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families (KPIF) coverage but meet **all** of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the KPIF plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements, and only if your KPIF application is declined. If you qualify for both plans, we will enroll you in KPIF. Both plans will have the same benefits, but HIPAA rates may be significantly higher than KPIF rates. For information about your specific HIPAA plan rates, please call 1-800-464-4000.

Questionnaire

Please read Section A, then complete either Section B or Section C (but not both).

A. Please read the following HIPAA requirements and determine whether all five are true statements.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
2. My most recent health care coverage was through a group health plan, a governmental plan, or a church plan.
3. I have both elected and exhausted all continuation health care coverage available under federal (COBRA) and state continuation coverage laws.
4. I do not currently have other health care coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was **not** terminated for fraud or failure to pay premiums.

B. If all five statements are true, please instruct Kaiser Permanente whether you wish to enroll in a HIPAA plan in the event you do not qualify for KPIF by checking either Yes or No below:

- If I do not qualify for KPIF and I do qualify for HIPAA, I request that I be enrolled in HIPAA. 0 **Yes** 0 **No**

If you checked Yes, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership in HIPAA.

C. If any of these five statements is not true, please indicate your understanding that you do not qualify for HIPAA by checking Yes below:

- I understand that I do not qualify for HIPAA. 0 **Yes**

X _____

Signature **Date**

Use black ink only.

Kaiser Permanente for Individuals and Families Membership Application

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 about your current or past health can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 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 our Member Service Call Center toll free at 1-800-464-4000 to request assistance completing this questionnaire.** Kaiser Permanente does not discriminate based upon: 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; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

I. Each person in the family must complete a separate application for membership.

A. Height (without shoes) _____ Ft. _____ In. Weight (dressed) _____ Lbs.

B. 0 Male 0 Female

C. 0 Single 0 Married 0 Domestic partner (Please refer to *DF/EOC* for eligibility.)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name _____ First name _____

Previous medical record number _____

E. Membership application for:

Last name _____

0 Mr. 0 Mrs. 0 Miss 0 Ms. First name _____ MI _____

F. Date of birth _____

1. **How many times have you been hospitalized in the last 12 months, except for pregnancy?**
   0 Never 0 2 times
   0 1 time 0 3 or more times

2. **How many times have you required medical attention in the last 12 months, except for pregnancy?**
   0 0–2 times 0 6–8 times
   0 3–5 times 0 9 or more times

3. **Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?**
   0 Yes 0 No

4. **(a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?**
   0 ½ pack or less 0 2 or more packs
   0 1 pack 0 N/A
   0 1½ packs
   (b) For how long?
   0 9 years or less 0 20–29 years
   0 10–14 years 0 Over 30 years
   0 15–19 years 0 N/A

5. **In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?**
   0 Yes 0 No

6. **In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?**
   0 Yes 0 No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(Health questionnaire continues on page 2.)

I. Each person in the family must complete a separate application for membership. *(continued)*

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (*please check **all** that apply*):

- O AIDS, ARC
- O Sexually transmitted diseases
- O Hepatitis
- O Hernia not repaired/ GI reflux
- O Back/Neck pain or injury
- O Bone marrow transplant
- O Crohn's or ulcerative colitis
- O Depression or anxiety
- O Mental health condition
- O Eating disorder, anorexia nervosa/bulimia
- O Heart or valve condition
- O Asthma
- O Emphysema/COPD
- O Lung condition, other chronic condition
- O High blood pressure
- O High cholesterol
- O Kidney/Bladder condition incl. kidney stones
- O Liver condition
- O Gallstones
- O Anemia or other blood disorder
- O Ulcer
- O Painful menstrual cycle or female reproductive disorder
- O Lupus/SLE
- O Silicone breast implants
- O Melanoma/ Breast/Prostate/ Bladder cancer
- O Skin cancer
- O Other cancers
- O Aneurysm
- O MS/ALS/ Parkinson's/ Alzheimer's
- O Neurologic condition
- O Pacemaker
- O Prostate condition
- O Rheumatoid arthritis
- O Seizures
- O Sickle cell anemia
- O Diabetes
- O Stomach or intestinal problems
- O Stroke
- O Lumps

O Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____

_____

O **None of the above**

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

O Yes O No

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

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

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- O Fever
- O Swollen glands
- O Chest pain
- O Shortness of breath
- O Abdominal or pelvic pain
- O Loss of consciousness
- O Unexplained weight loss
- O Rectal bleeding
- O Loss of appetite
- O Dizziness
- O Chronic fatigue
- O Rash
- O Skin lesions
- O Lumps

O Chronic pain (if Yes, please explain): _____

_____

O **None of the above**

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication here: _____

_____

_____

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

O Yes O No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

O Yes O No

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

[ ] / [ ] / [ ]
Month Day Year

Please review the health questionnaire to be sure you have answered all questions, 1–13.

II. Billing information (head of household only)

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

First name MI

0 Mr. 0 Mrs.
0 Miss 0 Ms.

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City State ZIP code

2. Account information
- 0 Addition of a family member to an existing account
- 0 Switching coverage from an existing account
- 0 New account

3. For which plan would you like to apply?
- 0 $1,500 Deductible Plan
- 0 $1,000 Deductible Plan
- 0 $500 Deductible Plan
- 0 $50 Copayment Plan
- 0 $25 Copayment Plan
- 0 $30/$2,700 Deductible Plan with HSA
- 0 $0/$2,700 Deductible Plan with HSA
- 0 $0/$1,500 Deductible Plan with HSA

4. Are you applying for the optional dental plan?

0 No 0 Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente medical record number

6. Home phone

7. Work phone

8. Primary language:
- 0 English
- 0 Other_____

For Applicants using an insurance broker:

9. Broker name

HEALTH PLAN ONE

10. Broker ID

20953

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

III. Family to be covered (other than head of household) Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse						
Child						
Child						
Child						
Child						
Child						

All Applicants: Please read the following information prior to signing 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.

IV. 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 will be based primarily on health information you provide in your application and during the enrollment process. If you are unsure of your current medical status, 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 prior to making our decision. We may review your use of health care services for up to a year following your KPIF enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KPIF enrollment.

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 determine that you or someone on your behalf intentionally gave us incomplete or incorrect material information about your current or past health in your application or during the enrollment process, and our decision to accept your enrollment was based, in whole or in part, on the misinformation, we will rescind your membership (completely void your membership so that no coverage ever existed). You will be required to pay as a nonmember for any services we provided or covered. Please refer to the *Disclosure Form* for more information about rescission of membership.

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**

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 black ink only**.

V. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for small claims court cases) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Disclosure Form and Evidence of Coverage.*

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**

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 black ink only**.

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_____

VI. 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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]).** 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 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 coverage.

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 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 Medical Information, HIV/AIDS- or ARC-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 thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claimfor benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy ofthis 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.

(continues)

VI. Authorization to Obtain or Release Medical Information *(continued)*

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 are 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**

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 black ink only**.

VII. HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in Section A of the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families (KPIF) coverage but meet **all** of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the KPIF plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements, and only if your KPIF application is declined. If you qualify for both plans, we will enroll you in KPIF. Both plans will have the same benefits, but HIPAA rates may be significantly higher than KPIF rates. For information about your specific HIPAA plan rates, please call 1-800-464-4000.

Questionnaire

Please read Section A, then complete either Section B or Section C (but not both).

A. Please read the following HIPAA requirements and determine whether all five are true statements.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
2. My most recent health care coverage was through a group health plan, a governmental plan, or a church plan.
3. I have both elected and exhausted all continuation health care coverage available under federal (COBRA) and state continuation coverage laws.
4. I do not currently have other health care coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was **not** terminated for fraud or failure to pay premiums.

B. If all five statements are true, please instruct Kaiser Permanente whether you wish to enroll in a HIPAA plan in the event you do not qualify for KPIF by checking either Yes or No below:

- If I do not qualify for KPIF and I do qualify for HIPAA, I request that I be enrolled in HIPAA. 0 **Yes** 0 **No**

If you checked Yes, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership in HIPAA.

C. If any of these five statements is not true, please indicate your understanding that you do not qualify for HIPAA by checking Yes below:

- I understand that I do not qualify for HIPAA. 0 **Yes**

X _____

Signature **Date**

Use black ink only.

Kaiser Permanente for Individuals and Families Membership Application

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 about your current or past health can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 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 our Member Service Call Center toll free at 1-800-464-4000 to request assistance completing this questionnaire.** Kaiser Permanente does not discriminate based upon: 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; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

I. Each person in the family must complete a separate application for membership.

A. Height (without shoes) _____ Ft. _____ In. Weight (dressed) _____ Lbs.

B. 0 Male 0 Female

C. 0 Single 0 Married 0 Domestic partner (Please refer to *DF/EOC* for eligibility.)

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name _____ First name _____

Previous medical record number _____

E. Membership application for:

Last name _____

0 Mr. 0 Mrs. 0 Miss 0 Ms. First name _____ MI _____

F. Date of birth _____

1. **How many times have you been hospitalized in the last 12 months, except for pregnancy?**
   0 Never 0 2 times
   0 1 time 0 3 or more times

2. **How many times have you required medical attention in the last 12 months, except for pregnancy?**
   0 0–2 times 0 6–8 times
   0 3–5 times 0 9 or more times

3. **Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?**
   0 Yes 0 No

4. **(a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?**
   0 ½ pack or less 0 2 or more packs
   0 1 pack 0 N/A
   0 1½ packs
   (b) For how long?
   0 9 years or less 0 20–29 years
   0 10–14 years 0 Over 30 years
   0 15–19 years 0 N/A

5. **In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?**
   0 Yes 0 No

6. **In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?**
   0 Yes 0 No

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(Health questionnaire continues on page 2.)

I. Each person in the family must complete a separate application for membership. *(continued)*

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (*please check **all** that apply*):

- O AIDS, ARC
- O Sexually transmitted diseases
- O Hepatitis
- O Hernia not repaired/ GI reflux
- O Back/Neck pain or injury
- O Bone marrow transplant
- O Crohn's or ulcerative colitis
- O Depression or anxiety
- O Mental health condition
- O Eating disorder, anorexia nervosa/bulimia
- O Heart or valve condition
- O Asthma
- O Emphysema/COPD
- O Lung condition, other chronic condition
- O High blood pressure
- O High cholesterol
- O Kidney/Bladder condition incl. kidney stones
- O Liver condition
- O Gallstones
- O Anemia or other blood disorder
- O Ulcer
- O Painful menstrual cycle or female reproductive disorder
- O Lupus/SLE
- O Silicone breast implants
- O Melanoma/ Breast/Prostate/ Bladder cancer
- O Skin cancer
- O Other cancers
- O Aneurysm
- O MS/ALS/ Parkinson's/ Alzheimer's
- O Neurologic condition
- O Pacemaker
- O Prostate condition
- O Rheumatoid arthritis
- O Seizures
- O Sickle cell anemia
- O Diabetes
- O Stomach or intestinal problems
- O Stroke
- O Lumps

O Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____

_____

O **None of the above**

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

O Yes O No

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

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

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- O Fever
- O Swollen glands
- O Chest pain
- O Shortness of breath
- O Abdominal or pelvic pain
- O Loss of consciousness
- O Unexplained weight loss
- O Rectal bleeding
- O Loss of appetite
- O Dizziness
- O Chronic fatigue
- O Rash
- O Skin lesions
- O Lumps

O Chronic pain (if Yes, please explain): _____

_____

O **None of the above**

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication here: _____

_____

_____

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

O Yes O No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

O Yes O No

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

[ ] / [ ] / [ ]
Month Day Year

Please review the health questionnaire to be sure you have answered all questions, 1–13.

II. Billing information (head of household only)

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

First name MI

0 Mr. 0 Mrs.
0 Miss 0 Ms.

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City State ZIP code

2. Account information
- 0 Addition of a family member to an existing account
- 0 Switching coverage from an existing account
- 0 New account

3. For which plan would you like to apply?
- 0 $1,500 Deductible Plan
- 0 $1,000 Deductible Plan
- 0 $500 Deductible Plan
- 0 $50 Copayment Plan
- 0 $25 Copayment Plan
- 0 $30/$2,700 Deductible Plan with HSA
- 0 $0/$2,700 Deductible Plan with HSA
- 0 $0/$1,500 Deductible Plan with HSA

4. Are you applying for the optional dental plan?

0 No 0 Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

5. Kaiser Permanente medical record number

6. Home phone

7. Work phone

8. Primary language:
- 0 English
- 0 Other_____

For Applicants using an insurance broker:

9. Broker name

HEALTH PLAN ONE

10. Broker ID

20953

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

III. Family to be covered (other than head of household) Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse						
Child						
Child						
Child						
Child						
Child						

All Applicants: Please read the following information prior to signing 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.

IV. Conditions of Acceptance

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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**

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 black ink only**.

V. Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for small claims court cases) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement and Disclosure Form and Evidence of Coverage.*

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X _____ **Applicant's spouse**	**Today's date**
X _____ **Applicant/Dependent (age 18 or over)**	**Today's date**

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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_____

VI. 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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]).** 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 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 coverage.

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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 Medical Information, HIV/AIDS- or ARC-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

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(continues)

VI. Authorization to Obtain or Release Medical Information *(continued)*

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 are 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**

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 black ink only**.

VII. HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in Section A of the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for Kaiser Permanente for Individuals and Families (KPIF) coverage but meet **all** of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the KPIF plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements, and only if your KPIF application is declined. If you qualify for both plans, we will enroll you in KPIF. Both plans will have the same benefits, but HIPAA rates may be significantly higher than KPIF rates. For information about your specific HIPAA plan rates, please call 1-800-464-4000.

Questionnaire

Please read Section A, then complete either Section B or Section C (but not both).

A. Please read the following HIPAA requirements and determine whether all five are true statements.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.

2. My most recent health care coverage was through a group health plan, a governmental plan, or a church plan.

3. I have both elected and exhausted all continuation health care coverage available under federal (COBRA) and state continuation coverage laws.

4. I do not currently have other health care coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.

5. My most recent coverage was **not** terminated for fraud or failure to pay premiums.

B. If all five statements are true, please instruct Kaiser Permanente whether you wish to enroll in a HIPAA plan in the event you do not qualify for KPIF by checking either Yes or No below:

• If I do not qualify for KPIF and I do qualify for HIPAA, I request that I be enrolled in HIPAA. 0 **Yes** 0 **No**

If you checked Yes, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership in HIPAA.

C. If any of these five statements is not true, please indicate your understanding that you do not qualify for HIPAA by checking Yes below:

• I understand that I do not qualify for HIPAA. 0 **Yes**

X _____

Signature **Date**

Use black ink only.