Application for health coverage

Who can use this application?

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

- If you want coverage for your family on the same Kaiser Permanente plan, please fill out 1 application for the family.
- If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for Kaiser Permanente coverage, you must live in our California service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, do not complete this application. You must apply for coverage through Covered California at coveredca.com.

Apply faster online

- You can apply faster online at **buykp.org/apply**.
- If you would like to email us, please apply online and set up a secure email account.

Things to remember

- Please answer all questions and type or print using ink only.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you are applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period guide and include any required documentation so your application will be complete. Your effective date may be different than the dates listed above, if you apply because of a special enrollment period.
- To avoid being billed twice, if you are enrolled in a plan through Covered California, you must cancel that plan on or before the effective date of your new plan.
- **Make sure your application is complete, signed, and includes your 1st month's premium payment. If your application is incomplete or does not include your 1st month's payment, it may be canceled.**
- Send your complete, signed application and 1st month's premium payment by mail to:

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

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

  Note: Checks must be mailed and cannot be faxed.

Need help?

- For help completing this application, please call **1-800-494-5314.** For TTY for the deaf, hard of hearing, or speech impaired, call **711.**
- **We will provide language assistance at no cost to you.**
- If you are working with a broker, please call him or her for assistance.

Step 1: Tell Us When You're Applying

Select one option:
- ○ Open enrollment
- ○ A special enrollment period

If you are applying during a special enrollment period, please write the date of your triggering event
_____/_____/_____

If you selected "A special enrollment period," choose the triggering event:
- ○ Loss of health care coverage
- ○ Gaining or becoming a dependent through marriage
- ○ Gaining or becoming a dependent through the birth of a child, or adoption, or foster care
- ○ Losing a dependent through divorce or legal separation
- ○ Death of the subscriber or a dependent
- ○ Court order
- ○ Permanent relocation
- ○ Release from incarceration
- ○ Change in eligibility for federal financial assistance through Covered California*
- ○ Change in eligibility for employer health coverage
- ○ Determination by Covered California
- ○ Misinformation about coverage
- ○ Provider network changes
- ○ Grandfathered plan renews outside open enrollment

*If you will be getting federal financial assistance, do not use this form. We can help you apply through Covered California.

Step 2: Choose Your Health Plan

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

Bronze
- ○ Kaiser Permanente – Bronze 60 HSA HMO 5500/40%
- ○ Kaiser Permanente – Bronze 60 HMO
- ○ Kaiser Permanente – Bronze 60 HSA HMO

Silver
- ○ Kaiser Permanente – Silver 70 HMO
- ○ Kaiser Permanente – Silver 70 HMO 1500/40
- ○ Kaiser Permanente – Silver 70 HSA HMO 2700/15%

Gold
- ○ Kaiser Permanente – Gold 80 HMO Copay
- ○ Kaiser Permanente – Gold 80 HMO Coinsurance

Platinum
- ○ Kaiser Permanente – Platinum 90 HMO

MINIMUM COVERAGE PLAN

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

- ○ Kaiser Permanente – Minimum Coverage

For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment materials. To request a copy of the *Membership Agreement, Disclosure Form, and Evidence of Coverage* for a particular plan, please call **1-800-464-4000** (TTY **711**) or contact your broker.

Step 3: Choose Your Optional Dental Plan

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. Please choose 1 option below.

- ○ Yes. I would like to enroll in the optional Dental Insurance Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.
- ○ No. I am not interested in optional dental coverage.

Step 4: Enter Your Information

Primary Applicant

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

First name	Middle name	Last name
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Home address (no P.O. boxes, please)		Apt. number
City	State / ZIP	County
Mailing address (if different from home address)		Apt. number
City	State / ZIP	County
Main phone ( ) –	Other phone ( ) –	Preferred language spoken (if not English) / Preferred language read (if not English)

Spouse/Domestic Partner to Be Covered

A domestic partner is a person registered and legally recognized as your domestic partner by California.

First name	Middle name	Last name
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

Dependents to Be Covered

If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)		Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)		Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)		Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)		Medical record number (if any)

Step 5: Parent or Legal Guardian (if the primary applicant is a child under age 18)

First name	Middle name	Last name	Gender ○ M ○ F	Date of birth (mm/dd/yyyy)

Same address as primary applicant? ○ Yes ○ No If no, fill in your address below.

Billing address	Apt. number

City	State	ZIP	County

Main phone	Other phone	Preferred language spoken (if not English)	Preferred language read (if not English)
( ) –	( ) –		

Step 6: Choose an Authorized Representative (if you have one)

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

First name	Middle name	Last name

Street address	Apt. number

City	State	ZIP	County

Phone
( ) –

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

Primary applicant or parent or legal guardian if the primary applicant is a child under age 18.	Date (mm/dd/yyyy)
X	

Step 7: Sign the Application Agreement

Important: All applicants and dependents 18 or older must read, sign, and date below. If the primary applicant is a child under age 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. If signatures are missing, we cannot continue processing the application.

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- I know that discrimination isn't permitted on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, or religion. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file or www.healthhelp.ca.gov or www.dfeh.ca.gov or www.insurance.ca.gov.

The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **1-800-634-4579** (TTY **711**).

Primary applicant (parent or legal guardian for children under age 18) X	Date (mm/dd/yyyy)
Spouse/Domestic partner X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)

Step 8: Sign the Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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, Disclosure Form, and Evidence of Coverage.*

Primary applicant or parent or legal guardian for children under age 18 X	Date (mm/dd/yyyy)
Spouse/Domestic partner X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)

Step 9: Enter Details for 1st Month's Premium Payment

These billing questions are processed securely and separately from the rest of your application.

Your application must be accompanied by payment for your 1st month's premium. If your payment or payment information is missing or incomplete, your application may be canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Don't send cash through the mail.

Billing Information

Complete the following information for the person responsible for making the payment. This is the primary applicant unless someone else is identified in Step 5 as the person responsible for making the payment.

First name	Middle name	Last name	Amount for your 1st month's premium
			$

Billing address	Apt. number

City	State	ZIP	County

Payment Options

Check your preferred payment option below and complete that section.

◯ **CREDIT/DEBIT CARD** If you are paying by credit or debit card, please complete the following information:

Credit/Debit card information: ◯ Credit ◯ Debit	◯ Visa ◯ MasterCard ◯ Discover ◯ American Express
Cardholder's name as it appears on card	
Credit/Debit card number	Expiration date (mm/yyyy)
Cardholder signature X	Date (mm/dd/yyyy)

◯ **ELECTRONIC PAYMENT**

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

Please debit: ◯ Checking account ◯ Savings account	Bank name
Routing number	Account number

(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)

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

◯ **CHECK** ◯ **MONEY ORDER**

If you are paying by check or money order:

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

KAISER PERMANENTE®

Primary applicant _____

Automatic Monthly Payments

For your convenience, if you paid your 1st month's premium by debit card, credit card, or electronic payment, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

Billing Information

Same billing as 1st month's premium? ◯ Yes ◯ No If no, complete the following information for the person responsible for making the payment.

First name	Middle name	Last name

Billing address	Apt. number

City	State	ZIP

Payment Options

I understand that if I have chosen the option to set up a repeating premium payment schedule and later wish to cancel or update it, I must do either of the following:

1. Go to **kp.org/payonline** and follow instructions to create a profile and cancel or update my repeating payment schedule.
2. Call the KFHP Member Service Contact Center at **1-800-464-4000** for assistance from a customer service representative to cancel or update my repeating payment schedule.

◯ CHARGE MY CREDIT CARD

By filling out this section, you are requesting that your premiums be automatically charged to your credit card on the 1st day of each month and agreeing to the terms outlined above.

Credit card information: ◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Cardholder's name as it appears on card	
Credit card number	**Expiration date (mm/yyyy)**
Cardholder signature X	**Date (mm/dd/yyyy)**

◯ DEDUCT FROM MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on the due date and agreeing to the terms outlined above.

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

Please debit: ◯ Checking account ◯ Savings account	**Bank name**
Routing number	**Account number**

(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)

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

◯ I AM NOT INTERESTED IN THE AUTOMATIC PAYMENT OPTION

For Applicants Using an Agent/Broker/KPIF Representative

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

Agent/Broker/KPIF representative first name	Middle name	Last name

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.

Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

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

Notice to agent, broker, KPIF representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

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

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

◯ **Yes** ◯ **No**

Agent/Broker/KPIF representative X	Date (mm/dd/yyyy)

Agent/Broker/KPIF representative (first, middle, last) (please print)	Kaiser Permanente–appointed broker identification number

Street address	Apt. number

City	State	ZIP

Phone	Fax	Email address
( ) –	( ) –	