

MEMBERSHIP APPLICATION FOR

Kaiser Permanente for Individuals and Families

Thank you for your interest in Kaiser Permanente for Individuals and Families! Please see the instructions inside for helpful information about filling out this application. Please keep a copy for your files. You and your authorized representative may request a copy of your completed application if needed.

NOTE: Applications are subject to medical review, and must be dated within 60 days of your requested effective date. Your responses to the questions in the "Medical Information" and "Other Health-Related Information" sections will be used to determine your acceptance to the plan and the appropriate premium rate. This application may become part of your permanent medical record if your membership is approved. It may be reviewed again by you with a physician.

Your payment must be received prior to final processing.

NOTE ABOUT BALANCE PLANS: This application includes an option to apply for an Alternative Health Benefit Plan, called Kaiser Permanente Balance Plans. These plans do not provide all of the state mandated health benefits normally required in accident and sickness insurance policies in Georgia. The Balance plans may provide a more affordable health insurance policy for you, although, at the same time, they may provide you with fewer health benefits than those normally included as state mandated health benefits in policies in Georgia. If you choose a Balance plan, please consult an insurance agent to discover which state mandated health benefits are excluded in this policy.

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736



INSTRUCTIONS:

- Please answer all questions completely to ensure timely processing of your application.
- Use only black or blue ink.
- Completely fill in the squares. Example:
- Print clearly above the lines or inside the boxes.
- Please select a Primary Care Physician (PCP) for each family member applying. For a searchable online physician directory, visit kp.org/medicalstaff. You may also call Member Services at **(404) 261-2590** for assistance. For your convenience, if you do not select a PCP, we will assist you by identifying a doctor near your home and temporarily listing that doctor as your personal physician. You may change your personal physician at any time simply by calling Member Services.
- Remember to sign all the appropriate boxes on the Application Agreement (page 6). Each applicant age 12 and over is required to sign the Authorization to Obtain or Release Medical Information.
- Remember to complete the Payment Options section (page 7), and include a check, money order, or credit card information for the first month's premium.
- If you choose to apply for a Kaiser Permanente *Balance Plan*, please complete the *Balance Plan Acknowledgement Form* at the end of this application.

Broker Information:

BROKER NAME: _____
AGENT # <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

General Agency Stamp (if applicable)

For Office Use Only:

Underwriter _____ Effective Date _____

Primary _____ Spouse _____ DI _____ D2 _____ D3 _____

1. PERSONAL INFORMATION — PRIMARY APPLICANT

As the oldest person applying for coverage, I am the primary applicant and hereby apply for membership in Kaiser Permanente based on the following:

Select One: Mr. Mrs. Ms. Miss Dr.

Marital Status: Single Married Widowed Divorced

Last Name	First Name	MI	Social Security #	Birth date	Height	Weight	Sex	Prior HRN*
			- -	MM/DD/YY	(ft./in.)	(lbs.)	M/F	

Street Address (cannot be a P.O. Box) _____ Apt. # _____

City _____ State _____ County _____ ZIP Code _____

Home Phone _____ Work Phone _____ E-mail Address _____

Is the billing address different than the address listed above? Yes No If Yes, please list the billing address below:

Billing Street Address _____ Apt. # or P.O. Box _____

City _____ State _____ ZIP Code _____

Please select a Primary Care Physician (PCP) for each person applying. (For a searchable online physician directory, visit kp.org/medicalstaff.) Physician Name _____ Physician ID _____

Please complete the following information for each additional person applying. If more space is needed for additional applicants, please attach another application and complete just the information for those additional applicants.

Spouse

Last Name	First Name	MI	Social Security #	Birth date	Height	Weight	Sex	Prior HRN*
			- -	MM/DD/YY	(ft./in.)	(lbs.)	M/F	

PCP Selection: Physician Name _____ Physician ID _____

Dependent 1 (D1) Relationship - Son Daughter Other (_____)

Last Name	First Name	MI	Social Security #	Birth date	Height	Weight	Sex	Prior HRN*
			- -	MM/DD/YY	(ft./in.)	(lbs.)	M/F	

PCP Selection: Physician Name _____ Physician ID _____

Dependent 2 (D2) Relationship - Son Daughter Other (_____)

Last Name	First Name	MI	Social Security #	Birth date	Height	Weight	Sex	Prior HRN*
			- -	MM/DD/YY	(ft./in.)	(lbs.)	M/F	

PCP Selection: Physician Name _____ Physician ID _____

Dependent 3 (D3) Relationship - Son Daughter Other (_____)

Last Name	First Name	MI	Social Security #	Birth date	Height	Weight	Sex	Prior HRN*
			- -	MM/DD/YY	(ft./in.)	(lbs.)	M/F	

PCP Selection: Physician Name _____ Physician ID _____

* Prior Kaiser Permanente Health Record Number (HRN), if applicable.

In the past five years, has any applicant applying for coverage been declined, postponed, charged an additional premium, or had a waiver applied for any form of health, life or disability insurance? Check one: Yes No

If yes, please provide the following details:

Applicant name	Reason
1.	
2.	
3.	

Do you, your spouse, and/or children currently have health coverage? Yes No

If yes, who is covered? (check all that apply)

Primary Subscriber Spouse Dependent 1 Dependent 2 Dependent 3

Provide the name of your current (or most recent) health insurance carrier and if applicable, the date of termination.

Carrier Name _____ Date of Termination _____

2. PLAN SELECTION

a) Fill in the box next to your requested plan type and write the full name of the plan on the line below it. (See your enrollment materials, contact your broker, or visit kp.org/care for plan choices and complete plan descriptions.)

HMO Plan

(full plan name, e.g. "Plan 3,000")

Balance HMO Plan

(full plan name, e.g. "Balance HMO 3,000")

**Balance HSA-Qualified
Deductible HMO Plan**

(full plan name, e.g. "Balance HSA 1,200/
100%")

Now Plan

(full plan name, e.g. "Now 2,000 Plus")

HSA-Qualified Deductible HMO Plan

(full plan name, e.g. "HSA Option 3,500/
100% Family")

b) Requested Effective Date of Coverage Month _____ Year _____

The earliest your coverage will begin is the first of the month following receipt of a completed application and first month's premium. Coverage will not be back-dated. If you are applying for a Kaiser Permanente Balance plan, each member of your family accepted for coverage will be enrolled in individual coverage. Dependent and family coverage are not available in the Balance plans.

Has any applicant ever been a Kaiser Permanente of Georgia member? Yes No

If Yes, please be sure you have written their prior Kaiser Permanente Health Record Number (HRN), if known, in their "Prior HRN" box on the page 1.

Type of Application:

New coverage Addition of a family member to an existing Kaiser Permanente member's coverage

Existing member's Health Record Number (HRN) _____

If you are adding a new member to your current plan, please note:

- If the family member you are adding is the oldest member of your family on the plan, this person will become the Primary Subscriber. Your monthly premium will be based on the age of the new, older family member (Primary Subscriber), and your new contract period will be based on the effective date of this new, older member.
- You may only add a new family member if your current plan is actively marketed, unless the additional member is a new born child and the addition is within the first 31 days of life.

What if all family members are not accepted?

Please remember that Kaiser Permanente's for Individuals and Families plans are individually underwritten. Each family member must pass a medical review. It is possible that some or all family members may not be accepted. In the event that not all family members are accepted, please instruct us how to handle accepted family members:

Please enroll any accepted family members.

Please cancel the enrollment process for any accepted family members and return my first month's premium check.

3. MEDICAL INFORMATION

■ Answer the questions below with respect to yourself and each family member applying for coverage.

■ If you can answer Yes for any applicant, fill in the Yes box and explain further—for each person the Yes applies to—on the chart in Question 9.

Have you or any family member applying for coverage:

1. been seen in a hospital emergency room or been admitted to a hospital, outpatient surgical center, or other treatment facility at any time in the last 24 months?
 Yes No
2. within the last 3 years, undergone any surgery, treatment, examination, evaluation, or test for any medical or mental health condition?
 Yes No
3. within the last 3 years, been advised to have, but have not yet had, any surgery, treatment, examination, evaluation, or test for any medical condition?
 Yes No
4. in the last 5 years, taken or used any illegal drugs, or any prescription drugs without a prescription written specifically for the applicant?
 Yes No
5. in the last 5 years, been seen or examined by a physician, health care professional, counselor, therapist, social worker, or any medically related professional for symptoms of alcohol and/or substance abuse, or participated in or been advised to participate in any program (including Alcoholics or Narcotics Anonymous) that deals with alcohol and/or substance abuse?
 Yes No
6. in the last 10 years, been seen, examined, or treated for; advised that you have; been prescribed or taken any medication for; had signs or symptoms of; or had any intention to seek advice or treatment for any of the following conditions? Please mark all that apply.
 - AIDS, HIV
 - Sexually transmitted disease
 - Hepatitis
 - Hernia not repaired
 - Back/neck pain or injury including herniated/degenerative disc or scoliosis
 - Broken bone/fracture (open, closed, pins, plates, or screws)
 - Bone marrow transplant
 - Crohn's or ulcerative colitis
 - Depression or anxiety
 - Mental health condition including bipolar disorder, schizophrenia, and/or manic depression
 - Eating disorder, anorexia nervosa/bulimia
 - Heart or valve condition
 - Asthma
 - Emphysema/COPD
 - Lung condition
 - High blood pressure
 - High cholesterol

- Kidney/bladder condition — including kidney stones
- Liver condition or pancreas disorder
- Gallstones
- Anemia or other blood disorder
- Painful or irregular menses or any condition, disorder, or abnormality of the male or female reproductive organs?
- Lupus/SLE/inflammatory condition
- Breast implants Saline: _____ Silicone: _____
- Melanoma/breast/prostate/bladder cancer
- Skin cancer
- Other cancers
- Aneurysm
- MS/ALS/Parkinson's/Alzheimer's
- Neurologic condition
- Pacemaker or other implanted medical device
- Prostate condition
- Rheumatoid arthritis
- Seizures/headaches requiring medical treatment
- Sickle cell anemia
- Diabetes
- Stomach or intestinal problems or GI reflux
- Stroke
- Lumps (including fibrocystic breasts), masses, tumors (including uterine fibroids), polyps, or growths
- Ulcer
- Infertility
- None of the above

7. within the last 3 years, experienced any of the following symptoms that were unexplained or undiagnosed? Please mark all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Abdominal or pelvic pain | <input type="checkbox"/> Rash/skin problems |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Skin lesions |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> None of the above |

8. Please list any other condition, disorder, abnormality, or symptom not listed on this application, even if not currently under treatment.

9. If you indicated a Yes answer for any of the items in **questions 1-8**, please explain below.
 If additional space is needed, list the information on a separate sheet of paper and attach it to this application.

Question Number	Person Treated	Purpose of visit/Name of Illness or Disorder	Treatment/Advice Given	Treatment Dates		Name and Address of Health Care Provider
				Start/End	Full Recovery?	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	
				/	Yes/No	

10. (a) In the past 12 months, have you or any family member applying for coverage been prescribed, taken, or been advised to take any prescription medication for any reason (including Depo-Provera or other birth control medication)?

Yes No

(b) If Yes, please explain below. If additional space is needed, list the information on a separate sheet of paper and attach it to this application.

Person Treated	Name of Medication	Dosage/Frequency	Treatment Dates		Name and Address of Attending Physician
			From	To	

Answer the questions below for yourself and each family member applying for coverage. (D1, D2, and D3 should correspond to the Dependents you listed under Additional Applicants in the Personal Information section.) Choose the one most appropriate answer for each person applying (regardless of age) and mark an X in that box. Write in numeric answers when asked.

11. Are you an expectant parent or do you have a pending adoption?

	Self	Spouse	D1	D2	D3
Yes					
No					

Answer questions 12-15 for each female applicant.

12. In the last 10 years, have you, or any applicant applying for coverage, had a C-section?

	Self	Spouse	D1	D2	D3
Yes					
No					

13. In the last 10 years, have you, or any applicant applying for coverage, had a delivery that resulted in a premature birth?

	Self	Spouse	D1	D2	D3
Yes					
No					

14. (a) For females over age 11 only: Are you 1. pre-menstrual (have never menstruated), 2. post-menopausal, or 3. have you had a hysterectomy or tubal ligation? If Yes, please write in the number (1, 2, or 3) of the one that applies in the box for the appropriate person.

	Self	Spouse	D1	D2	D3
Yes					
No					

14 (b) If No, first day of your last menstrual period:

Self	Spouse	D1	D2	D3
MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

14 (c) Do you have regular monthly menstrual periods with 28-30 days between the first day of one period and the first day of the next period?

	Self	Spouse	D1	D2	D3
Yes					
No					

15. Are you currently breast feeding or have you stopped within the last three months?

	Self	Spouse	D1	D2	D3
Yes					
No					

4. OTHER HEALTH-RELATED QUESTIONS

1. (a) Have you consumed more than 10 alcoholic beverages per week within the last 6 months? (One drink equals 12 oz. beer, 4 oz. glass of wine, 1 oz. hard liquor)

	Self	Spouse	D1	D2	D3
Yes					
No					

1 (b) If Yes for 1 (a), write in the number of drinks consumed weekly.

	Self	Spouse	D1	D2	D3
Beer					
Wine					
Hard liquor					

2. Have you or any family member applying for coverage ever been advised to reduce alcohol consumption?

	Self	Spouse	D1	D2	D3
Yes					
No					

3 (a) If you have ever smoked cigarettes, what is or was your average daily usage?

	Self	Spouse	D1	D2	D3
½ pack or less					
1 pack					
1½ packs					
2 or more packs					
N/A					

3 (b) For how long?

	Self	Spouse	D1	D2	D3
9 years or less					
10-14 years					
15-19 years					
20-29 years					
Over 30 years					
N/A					

3 (c) Have you quit?

	Self	Spouse	D1	D2	D3
Yes					
No					
If so, when?	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY

5. APPLICATION AGREEMENT

I hereby apply for enrollment for myself and eligible family dependents listed on this form, and I agree that the information listed is correct. Upon acceptance to the Health Plan, my enclosed check for the first month's premium will be deposited or my credit card charged, and my coverage will begin on the first day of the month as assigned by Health Plan.

NOTICES:

1. Any intentional material misstatement or omission of information may void your coverage and/or the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

2. YOU MUST IMMEDIATELY INFORM US if your health status or current medication changes at any time before your membership with Kaiser Permanente becomes effective. Failure to inform us of such changes can void your membership. You can choose to update your application information by telephone (404) 364-7001 (option 2), by fax (404) 365-4146, or by writing us at Kaiser Permanente for Individuals and Families; 3495 Piedmont Road, NE; Building 9; Atlanta, GA 30305. All written and fax correspondence must be signed and dated.

3. After the effective date of this coverage, Health Plan may rescind your coverage and your dependent's coverage retroactively to the effective date (1) based on updated information, (2) upon learning that you failed to provide updated information, OR (3) upon learning that you intentionally provided any incorrect or incomplete answers on this application or in communications regarding it. If your coverage is rescinded, you will be billed for all services you received.

4. Georgia residents who do not qualify for Kaiser Permanente for Individuals and Families and are not current Kaiser Foundation Health Plan members may be eligible to participate in the State of Georgia Health Insurance Assignment System, a state-sponsored guaranteed-issue health care coverage program in which Kaiser Permanente participates. For more information, call 1-800-656-2298. Georgia residents who do not qualify for Kaiser Permanente for Individuals and Families and who are current Kaiser Foundation Health Plan group members can choose to be considered for our conversion products, one of which is available to HIPAA-qualified individuals. If you wish to exercise that option, please contact our Customer Service Department at (404) 261-2590 to obtain an application.

IMPORTANT: Please read the conditions above, and sign and date below. All applications **MUST** be signed and dated by **Primary Applicant, Spouse (if applicable), and any Dependent 18 years of age or older (if applicable).** I have read and understand all of the above conditions and terms.

I authorize the disclosure of premium billing, claim payment, and commission information to my broker of record and my spouse (if applicable) to expedite the servicing of my account. Yes No

Signature of Primary Applicant	Date
Signature of Spouse	Date
Signature of parent or guardian if Primary Applicant is under 18	Date
Signature of <i>Dependent</i> if 18 years of age or older or emancipated minor	Date

A representative of Kaiser Permanente may contact you.

6. RELEASE INFORMATION

RELEASE AUTHORIZATION: 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 me or any of my dependents applying for, or having membership in any Kaiser Foundation Health Plan product (each, an "Applicant"), or any insurance or reinsurance company, pharmacy benefits manager, or third party administrator to give Kaiser Foundation Health Plan of Georgia, Inc., or its affiliates ("Kaiser Permanente"), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, 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, or AIDS (Acquired Immune Deficiency Syndrome) ("Medical Information") of the Applicant. 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 (including medical underwriting) or of any claim for benefits after enrollment.

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 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 claim for benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy of this 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. 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 of any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's Notice of Privacy Practices.

Authorization to Obtain or Release Medical Information

IMPORTANT: All applications must be signed and dated by **Primary Applicant, Spouse (if applicable), and all applicants/dependents age 12 or over, and parents or legal guardians of enrollees age 12 to 17.**

Signature of Primary Applicant	Date
Signature of Spouse	Date
Signature of Applicant/Dependent (age 12 or older)	Date
Signature of Applicant/Dependent (age 12 or older)	Date
Signature of Applicant/Dependent (age 12 or older)	Date
Signature of parent or legal guardian of enrollee 12-17 years old	Date

7. PAYMENT OPTIONS

- Automatic Draft Plan*** Your most convenient and reliable option is this payment method. Payments are automatically deducted from your checking or savings account between the first and the fifth day of each month. To enroll, simply read and fill out the section below. BE SURE TO INCLUDE A VOIDED CHECK AND YOUR FIRST MONTH'S PREMIUM.

**Note: If you choose the Automatic Draft Plan as your payment option, you are still required to send a check, money order, or credit card information for your first month's premium, along with a voided check. If you'd like to pay your first month's premium by credit card, enter your credit card information in the Payment by Credit Card section, and select the "First Month's Premium Only" option. The automatic draft plan takes effect in your second month of coverage.*

I hereby authorize Kaiser Foundation Health Plan of Georgia, Inc., (Health Plan) to debit my checking or savings account with the financial institution named below. If a debit will differ from that of the previous month's debit, Health Plan will notify me in writing at least seven days in advance of the change.

This authority is to remain in full force and effect until Health Plan has received written notification from me of its termination in such time and in such manner as to afford Health Plan reasonable opportunity to act on it. (Must give Health Plan 30 days.)

If an entry is erroneously initiated by Health Plan to my account, I have the right to have the amount of the entry credited to my account. However, I must give the financial institution a written notice within 15 days explaining that the entry was in error.

Bank Name: _____ Member (Depositor) Account Number: _____

Bank Address: _____ Type of account (check one) Savings Account Other
_____ Checking Account
(Please attach a voided check)

Member Name(s): _____
(Please Print)

Signed: _____
(Member Signature)

Date: _____ Signed: _____
(Depositor Signature)

Date: _____ Signed: _____
(2nd Depositor Signature if Joint Account)

- Payment by Credit Card** Your credit card will be charged for your/your family's first month's premium. Also, each month's premium will be automatically charged to your credit card on or about the 20th of the month prior unless you arrange another form of payment by calling (404) 364-7179. Your credit card will be charged only if you are accepted for membership.

Type of card: _____ Credit card number: _____ Expiration date: _____

Name as it appears on card: _____ Signature: _____

Use this credit card for: All my monthly premiums First month's premium only

- Payment by Monthly Invoice*** You will receive a monthly invoice from Kaiser Permanente. Payment is due on or before the first day of each month. If payment is not received by this date, you are subject to termination of membership.

**Note: If you choose the "Payment by Monthly Invoice option," you are still required to send a check, money order, or credit card information for your first month's premium.*

If you do not choose a payment method, you will automatically receive a monthly invoice. You are still required to send your first month's premium.

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PERFORATION (DO NOT PRINT)

BALANCE PLAN ACKNOWLEDGEMENT FORM

For Balance Plan Applicants Only

If you are applying for a Kaiser Permanente Balance Plan, please read the following notice. If you are applying for any other type of plan, this notice does not apply, and you may simply disregard it.

In order to be enrolled in a Kaiser Permanente Balance Plan, you **MUST** sign this *Balance Plan Acknowledgement Form* and return it with this application. Failure to sign the form will delay your Kaiser Permanente enrollment.

Please also note that Balance plans offer individual coverage only. If your spouse and/or child(ren) would like to be enrolled in a Balance plan, they must each submit their own separate application, which will be subject to medical screening.

Acknowledgement of Limited Benefit Coverage

In choosing one of Kaiser Permanente's Balance Plans, I understand that these plans do not provide coverage for some state mandated benefits. The following is a comparison of benefits provided under Kaiser Permanente for Individuals and Families HMO plans that are either not covered or are significantly different under the Balance plans. If you have any questions about comparison of benefits between the HMO plans and the Balance plans, please call us at **1-800-697-0918** or contact your broker before you sign.

Benefit	Individual and Family HMO Plans	Individual and Family Balance Plans
Maximum Benefit While Covered	Unlimited	\$3,000,000
Maternity Services— (all services related to prenatal, postnatal, and delivery care)	Covered	No coverage
Infertility Diagnosis	Covered	No coverage
Vision Exams	Covered	No coverage
Dental Care— accidental injury	Covered	No coverage
Dental Care— Non-surgical dental treatment for TMJ, including dental splints	Covered	No coverage

I have read and understand the comparison of benefits between the plans being offered to me, and I understand the benefit limitations and exclusions of the Kaiser Permanente Balance plans.

Signature _____ Date _____

Printed Name _____

PERFORATION (DO NOT PRINT)

