

**Membership Application: Kaiser Permanente for Individuals and Families**

**Instructions:** You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan of Ohio member. Omissions or incomplete answers will delay processing of your application. **Intentional misrepresentation can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section IV on page 4 for details).** This application may become 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 **1-800-634-4579** 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.  Male  Female

C.  Single  Married

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

Mr.  Mrs.  Miss  Ms. First name  MI

F. Date of birth

1. How many times have you been hospitalized in the last 12 months, except for pregnancy?

- Never  2 times  
 1 time  3 or more times

2. How many times have you required medical attention in the last 12 months, except for pregnancy?

- 0-2 times  6-8 times  
 3-5 times  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?

- Yes  No

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

- ½ pack or less  2 or more packs  
 1 pack  N/A  
 1½ packs

(b) For how long?

- 9 years or less  20-29 years  
 10-14 years  Over 30 years  
 15-19 years  N/A

5. In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?

- Yes  No

6. In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?

- Yes  No

*(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):

- |   |  |
|---|--|
| <input type="checkbox"/> AIDS, ARC  | <input type="checkbox"/> Painful menstrual cycle or female reproductive disorder |
| <input type="checkbox"/> Sexually transmitted diseases  | <input type="checkbox"/> Lupus/SLE   |
| <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Silicone breast implants                                |
| <input type="checkbox"/> Hernia not repaired/<br>GI reflux  | <input type="checkbox"/> Melanoma/<br>Breast/Prostate/<br>Bladder cancer         |
| <input type="checkbox"/> Back/Neck pain or injury   | <input type="checkbox"/> Skin cancer   |
| <input type="checkbox"/> Bone marrow transplant   | <input type="checkbox"/> Other cancers   |
| <input type="checkbox"/> Crohn's or ulcerative colitis  | <input type="checkbox"/> Aneurysm  |
| <input type="checkbox"/> Depression or anxiety  | <input type="checkbox"/> MS/ALS/<br>Parkinson's/<br>Alzheimer's                  |
| <input type="checkbox"/> Mental health condition  | <input type="checkbox"/> Neurologic condition                                    |
| <input type="checkbox"/> Eating disorder, anorexia nervosa/bulimia  | <input type="checkbox"/> Pacemaker   |
| <input type="checkbox"/> Heart or valve condition   | <input type="checkbox"/> Prostate condition                                      |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Rheumatoid arthritis                                    |
| <input type="checkbox"/> Emphysema/COPD   | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Lung condition, other chronic condition  | <input type="checkbox"/> Sickle cell anemia                                      |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Stomach or intestinal problems                          |
| <input type="checkbox"/> Kidney/Bladder condition incl. kidney stones   | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Liver condition  | <input type="checkbox"/> Lumps   |
| <input type="checkbox"/> Gallstones   |  |
| <input type="checkbox"/> Anemia or other blood disorder   |  |
| <input type="checkbox"/> Ulcer  |  |
| <input type="checkbox"/> Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire: _____ |  |

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?

- Yes                       No

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

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

- |   |   |
|---|---|
| <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             |
| <input type="checkbox"/> Loss of consciousness                        | <input type="checkbox"/> Skin lesions     |
| <input type="checkbox"/> Unexplained weight loss                      | <input type="checkbox"/> Lumps            |
| <input type="checkbox"/> Chronic pain (if Yes, please explain): _____ |   |

None of the above

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

- Yes                       No

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

- Yes                       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?

- Yes                       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?

- Yes                       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 (subscriber only)**

The subscriber must complete Section II—Billing information, and Section III—Family to be covered.

**1. Person to be billed:**

Last name

First name

MI

Mr.  Mrs.  
 Miss  Ms.



Date of birth

Social Security number (SSN) or Taxpayer ID



Street address

Apt. number

City

State

ZIP code




**2. Account information**

- Addition of a family member to an existing account
- New account
- Change from one plan design to another

Please remember that applicants are individually underwritten for the Kaiser Permanente for Individuals and Families plan. 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 some family members are not accepted, please inform us how to handle the accepted family members by having the subscriber initial one of the following options:**

- Please enroll any accepted family members. I understand the actual premium may be different and will be based on who is accepted and enrolled and who is identified as the subscriber.
- Please cancel the enrollment process for accepted family members.

**3. For which plan would you like to apply?**

**Copayment**

- Plan 20
- Plan 25

**HSA-qualified**

- Plan 2500/5000
- Plan 5000/10000

**Deductible**

- Plan 500/1000
- Plan 1000/2000
- Plan 1500/3000

**4. Kaiser Permanente medical record number**

**5. Home phone**

**6. Work phone**

**7. Primary language**

- English
- Other \_\_\_\_\_

**For Applicants using an insurance broker:**

**8. Broker/General agent name**

**9. Broker/General agent ID**

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 care plan coverage.

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

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
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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. Any person obligated for any part of a premium may cancel such an agreement within 72 hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to Kaiser Foundation Health Plan of Ohio or its agents or other representatives. Notice of cancellation is considered given when the prospective subscriber mails a letter to Kaiser Foundation Health Plan of Ohio.

**IV. Conditions of Acceptance and Health Status Update**

**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 Kaiser Permanente for Individuals and Families membership, our decision would be based primarily on health information you provided in your application and would be conditioned on your actual health being consistent with the information you provided. If you are unsure of your current medical condition, 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 reserve the right to review your use of health services during your first year of membership to confirm consistency with your pre-enrollment health information.

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. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Note: If we discover that you intentionally provided incomplete or incorrect material information in the enrollment process, we will rescind your membership. This means that we will completely void membership so that no coverage ever existed. You will have to pay as a nonmember for any services we covered.**

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.

**Sign below to apply for membership and to affirm that all statements on this application are true. This application also serves as your request to participate in the Ohio Trust for Individual Dental Care Services (see section VI, page 5).**

<b>X</b>	
Applicant/Subscriber	Today's date
<b>X</b>	
Applicant's spouse	Today's date
<b>X</b>	
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 (subscriber, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. **Use black ink only.**

**V. 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 provides any services, whether before or after the date of this application, to me or any dependents on whose behalf I am executing this authorization in connection with our application for membership in any Kaiser Foundation Health Plan product (each, an *Applicant*), to give Kaiser Foundation Health Plan of Ohio or its affiliates (*Kaiser Permanente*), their respective agents, employees, designees, or representatives, **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) (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 or of any claim for benefits after enrollment.

I authorize Kaiser Permanente to disclose any and all such Medical Information 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 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 the coverage.

(continues)

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

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 and other information disclosed under this authorization, 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 and other 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*.

<b>X</b>	
<b>Applicant/Subscriber</b>	<b>Today's date</b>
<b>X</b>	
<b>Applicant's spouse</b>	<b>Today's date</b>
<b>X</b>	
<b>Applicant/Dependent (age 13 or over)</b>	<b>Today's date</b>

**Important:** Required signatures—all Applicants **age 13 or over must** sign and date above on the appropriate signature line (subscriber, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 13. **Use black ink only.**

**VI. Request for participation in Ohio Trust for Individual Dental Care Services**

**Note to Applicant:** This application for membership in Kaiser Permanente for Individuals and Families also serves as your request for participation in the Ohio Trust for Individual Dental Care Services (the Trust), which is administered by Delta Dental Plan of Ohio pursuant to an arrangement between Kaiser Permanente and Delta Dental Plan of Ohio. If you are accepted as a member of Kaiser Permanente for Individuals and Families, you will also be accepted as a participant in the Trust. Participation in the Trust is not optional. All Applicants accepted for membership in Kaiser Permanente for Individuals and Families will be enrolled automatically in the Trust and will receive dental benefits as a member under a group contract issued by Delta Dental Plan of Ohio to the Trust. If your membership in Kaiser Permanente for Individuals and Families terminates for any reason, your participation in the Trust and your dental benefits will also terminate. If the arrangement between Kaiser Permanente and Delta Dental Plan of Ohio terminates, the Trust will be terminated and your participation in the Trust and your dental benefits will also terminate. You will receive a certificate of coverage issued by Delta Dental Plan of Ohio describing your dental benefits. The premium charged for enrollment in Kaiser Permanente for Individuals and Families will include the premium for dental benefits under the group contract issued to the Trust by Delta Dental Plan of Ohio.

**By signing this application, I agree and affirm that:** (1) I am requesting participation in the Ohio Trust for Individual Dental Care Services, as amended; (2) the Trust is the holder of a group contract for dental care services issued by Delta Dental Plan of Ohio and all claims for benefits under that group contract must be made to Delta Dental Plan of Ohio; (3) I will be bound by the terms and conditions of the certificate of coverage issued by Delta Dental Plan of Ohio to me; and (4) my participation in the Trust will continue until the earlier to occur of (i) termination of my membership in Kaiser Foundation Health Plan of Ohio under a contract for Kaiser Permanente for Individuals and Families, as it may be renamed; (ii) termination of the group contract issued by Delta Dental Plan of Ohio to the Trust; or (iii) termination of the Trust.

**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 this application page and return it with pages 1–5 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 coverage but meet **ALL** of the following five requirements, you are guaranteed coverage in a Kaiser Permanente HIPAA plan with benefits most like the Kaiser Permanente for Individuals and Families plan to which you applied.\* If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA-qualified plan.

**Note: We will guarantee to enroll you in the applicable Kaiser Permanente HIPAA-qualified plan only if you meet HIPAA eligibility requirements, and only if your Kaiser Permanente for Individuals and Families application is declined. If you qualify for both plans, we will enroll you in Kaiser Permanente for Individuals and Families. HIPAA rates may be significantly higher than Kaiser Permanente for Individuals and Families rates.**

**\*You are responsible for choosing the HIPAA plan for which you would like to receive health coverage.** As part of a state-mandated program, Kaiser Foundation Health Plan of Ohio offers two HIPAA plans: HIPAA Basic and HIPAA Standard. For a comparison of rates and benefits between the two HIPAA plans, please review the HIPAA section of the enrollment booklet or call **1-800-524-7371, ext. 5613**.

**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.  Yes  No

**If you checked Yes, please attach or forward 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 creditable coverage, you will be enrolled for membership in HIPAA.

- If I qualify for HIPAA, please enroll me in (please check one of the following plans):  HIPAA Basic  HIPAA Standard

**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.  Yes

<b>X</b>	
Signature _____	Date _____

Use black ink only.

<b>For office use only:</b>	PH 0      CSC 0	AREA NO. _____
MEDICAL RECORD No. _____	FAMILY ACCOUNT No. _____	PURCHASER No. _____
DATE RECEIVED _____	STATUS: 0 APPROVED 0 DENIED	EFFECTIVE DATE _____