

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES MEMBERSHIP APPLICATION

Note: Please answer all questions and print or type **using ink only**. You should sign this application only if you understand each question and agree to the response provided—even if a broker assists you with the application. **If you have questions about completing this application (in English or another language), please call 1-800-634-4579. Or, if you are working with a broker, please call him or her for assistance.**

Kaiser Permanente for Individuals and Families (KPIF) offers family coverage and rates if everyone selects the same benefit plan. If you want coverage for your family on the same KPIF plan, please complete one application for the family. If one family member wants a different benefit plan, he or she must complete a separate application.

EXPEDITE YOUR APPLICATION – APPLY ONLINE NOW AT BUYKP.ORG/APPLY.

Application for Coverage (primary applicant)

Last name

First name

MI

Residential address:

Street address

Apt./Unit #

City

State

ZIP

Mailing address:

Street address or P.O. Box

Apt./Unit #

City

State

ZIP

(_____) _____ Day Evening
Home phone

(_____) _____ Day Evening
Work phone

E-mail address

Primary spoken language:

English
 Other (please specify) _____

For child-only accounts:

If primary applicant is a child, indicate financially responsible party's name and address, if different, below.

Last name

First name

Street address or P.O. Box

Apt./Unit #

City

State

ZIP

(continues on page 2)

II Account Information

Please check all boxes that apply.

1. Are you adding a family member to an existing Individuals and Families plan account?

Yes No

2. Are you a current Kaiser Permanente for Individuals and Families member requesting a plan change?

Yes No

3. Are you applying for a new Individuals and Families plan account?

Yes No

4. Which plan would you like to apply for?

(Select only one plan.)

Copayment:

- Plan 20
 Plan 25

Deductible:

- Plan 500/1000
 Plan 1000/2000
 Plan 1500/3000
 Plan 2500/5000

HSA-qualified:

- Plan 2500/5000 100/0
 Plan 2500/5000 80/20
 Plan 5000/10000 100/0

5. Effective date:

If approved, I would like to be enrolled with an effective date of:

- 15th of the current month (Your application must be received by the 8th of the current month.)
 1st of the next month (Your application must be received by the 23rd of the current month.)
 15th of the next month (Your application must be received by the 8th of the next month.)
 1st of the month after the next (Your application must be received by the 23rd of the next month.)

6. Because all applicants applying for an Individuals and Families plan are subject to medical review, there is the possibility that one or more members of a family may not be accepted. The actual premium may be different and will be based on who is accepted and enrolled.

If you or another family member are not accepted, may we complete the enrollment for family members who have been approved?

Yes No

If you do not qualify for a Kaiser Permanente for Individuals and Families plan, you may qualify for a HIPAA plan without medical review. Please refer to Section X, "HIPAA," on page 20.

Note: All applications must be accompanied by payment information. Please make certain that you have provided the necessary information on page 15 of this application.

III Family Members to Be Covered

If any family members have a different home address than the primary applicant, please list that address under their names. Attach additional pages if necessary.

Primary applicant:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number				

Spouse:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number		Home address (if different than primary applicant's)		

Child:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number		Home address (if different than primary applicant's)		

Child:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number		Home address (if different than primary applicant's)		

Child:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number		Home address (if different than primary applicant's)		

Child:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	

Social Security number		Home address (if different than primary applicant's)		

III Family Members to Be Covered *(continued)*

For each individual listed on page 3, please give the name of the family member's current or most recent primary care physician, along with his or her address and telephone number. Attach additional pages if necessary.

Primary applicant:

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Spouse:

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child: _____

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child: _____

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child: _____

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child: _____

Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

For each individual for whom you are applying, please give the name of his or her current or most recent health care coverage provider. Attach additional pages if necessary.

Primary applicant _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Spouse _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan of Ohio member. **Each applicant for a KPIF plan must meet underwriting criteria and pass medical review regardless of current or previous Kaiser Permanente coverage.** Omissions or incomplete answers will delay processing of your application. **Intentional misrepresentation can result in rescission of your coverage (see Section VII 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 1-800-634-4579 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.

Note: This is a family-level questionnaire. You must answer each question for yourself and for everyone you are applying for. Please answer Yes or No to each question. Each question that you answer Yes and each condition that you check Yes requires an explanation. Please see the chart on page 13 and provide the information requested.

Check the Yes or No box for each item. Every line must be answered Yes or No. When you answer each question, answer not only for yourself but for everyone you are applying for.

1. **Within the last 12 months**, were you (or anyone you are applying for) hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?
 Yes No

2. **Within the last 12 months**, have you (or anyone you are applying for) sought advice or treatment from a medical professional's office?
 - Yes No a) Physical exam
 - Yes No b) Minor illness or injury now resolved and without a recommendation of further treatment; for example, cold, allergic reaction, flu, sore throat, cut requiring stitches
 - Yes No c) Regular chiropractic visits
 - Yes No d) Prenatal care
 - Yes No e) Psychological counseling
 - Yes No f) Medication management
 - Yes No g) A reason not listed above

3. **Within the last 3 years**, have you (or anyone you are applying for) been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?
 Yes No

4. **Within the last 3 years**, have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with **your (or his/her)** alcohol or substance abuse?
 Yes No

(Medical questionnaire continues on page 6.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

5. **Within the last 3 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any skin/dermatological disorders?

- Yes No a) Acne
 Yes No b) Psoriasis
 Yes No c) Burns
 Yes No d) Keloids requiring plastic surgery
 Yes No e) Cosmetic or reconstructive surgeries, revisions
 Yes No f) A skin or dermatological condition not listed above

6. **Within the last 3 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any disorders of the eyes, ears, nose, or throat?

- Yes No a) Glaucoma
 Yes No b) Cataracts, cataract surgery for one or both eyes
 Yes No c) Crossed eyes
 Yes No d) Detached retina
 Yes No e) Macular degeneration
 Yes No f) Deviated septum
 Yes No g) Sleep apnea, chronic snoring, or unresolved insomnia
 Yes No h) Nasal and/or throat polyps
 Yes No i) A condition of the eyes, ears, nose, or throat not listed above

7. Have you (or anyone you are applying for) ever used tobacco, including snuff and chewing or other smokeless tobacco?

- Yes No

If Yes, please provide his or her name: _____

- Yes No a) Do not use currently, but used from age ____ to age ____
 Yes No b) If you smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:
 Cigarettes: ____ packs per day
 Pipes: ____ bowls per day
 Cigars: ____ per day

(If this question pertains to more than one person applying, please list additional name[s] and answers on page 13, using the format above.)

8. **Within the last 5 years**, have you (or anyone you are applying for) taken or used illegal drugs or prescription drugs not prescribed by a medical professional for yourself (or anyone you are applying for)?

- Yes No

9. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any brain, neurological, or nervous disorder?

- Yes No a) Multiple sclerosis
 Yes No b) Autism
 Yes No c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
 Yes No d) Seizures treated with more than 2 medications for control
 Yes No e) Seizures under control with 2 or fewer medications
 Yes No f) Most recent seizure within the last 12 months
 Yes No g) Alzheimer's disease
 Yes No h) A brain, neurological, or nervous disorder not listed above

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

10. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any heart or cardiovascular disorders?

- Yes No a) Aneurysm
- Yes No b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment
- Yes No c) Chest pain
- Yes No d) Heart attack or angina
- Yes No e) Congestive heart failure
- Yes No f) Angioplasty or coronary artery bypass
- Yes No g) Pacemaker
- Yes No h) Tachycardia or other heart arrhythmia
- Yes No i) Other heart disease or valve disease
- Yes No j) Current medication(s) to control heart disease or cardiovascular symptoms
- Yes No k) A heart or cardiovascular condition not listed above

11. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any respiratory disorders?

- Yes No a) Chronic asthma treated with medications for control
- Yes No b) Asthma treated with prednisone therapy
- Yes No c) Asthma treated only with occasional use of inhalers
- Yes No d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months
- Yes No e) Emphysema
- Yes No f) Chronic bronchitis
- Yes No g) Chronic obstructive pulmonary disease
- Yes No h) Cystic fibrosis
- Yes No i) Pulmonary tuberculosis, active or arrested
- Yes No j) A lung or respiratory disorder not listed above

12. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any muscle or bone disorders?

- Yes No a) Back or neck pain or injury currently under treatment or controlled with medication
- Yes No b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment
- Yes No c) Back or neck pain or injury for which further treatment or surgery has been recommended
- Yes No d) Inguinal hernia that has been repaired
- Yes No e) Inguinal hernia not repaired
- Yes No f) Umbilical hernia that has been repaired
- Yes No g) Umbilical hernia not repaired
- Yes No h) Lupus/SLE
- Yes No i) Chronic disabling arthritis
- Yes No j) Arthritis requiring daily prescription medication
- Yes No k) Osteomyelitis
- Yes No l) Joint replacement surgery
- Yes No m) Orthopedic or arthritic conditions that interfere with daily living
- Yes No n) A musculoskeletal condition not listed above

(Medical questionnaire continues on page 8.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

13. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any metabolic or endocrine (hormone) disorders?

- Yes No a) AIDS
- Yes No b) Diabetes controlled with oral medication
- Yes No c) Diabetes controlled with insulin
- Yes No d) Diabetes controlled exclusively with diet and exercise
- Yes No e) Gestational diabetes
- Yes No f) High cholesterol
- Yes No g) Rheumatoid arthritis
- Yes No h) Muscular dystrophy
- Yes No i) Other immunological condition
- Yes No j) A metabolic or endocrine disorder not listed above

14. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any congenital defects or developmental disorders?

- Yes No a) Down's syndrome
- Yes No b) Cerebral palsy
- Yes No c) Cleft palate or lip
- Yes No d) Club foot
- Yes No e) Congenital heart defect (specify type)
- Yes No f) Developmental delay
- Yes No g) Prematurity (for children up to 2 years old)
- Yes No h) A neurological or physical abnormality not listed above (specify)

15. **For men only: Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him) that any of you have, any of the following:

- Yes No a) Prostate condition requiring treatment, medication, or surgery
- Yes No b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months
- Yes No c) Genital warts
- Yes No d) Syphilis
- Yes No e) Gonorrhea
- Yes No f) Other sexually transmitted disease
- Yes No g) Impotence or erectile dysfunction
- Yes No h) Infertility
- Yes No i) Gender identity (role) disorder
- Yes No j) A male reproductive or genital disorder not listed above

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

16. For women only: **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or her) that any of you have, any of the following:

- Yes No a) Ovarian cyst operated on within the last 12 months
- Yes No b) Ovarian cyst controlled by birth control pills
- Yes No c) Polycystic ovary syndrome (PCOS)
- Yes No d) Endometriosis
- Yes No e) Chronic pelvic pain or pelvic inflammatory disease
- Yes No f) Painful or irregular menstrual cycles
- Yes No g) Uterine fibroids
- Yes No h) Silicone breast implants
- Yes No i) Saline breast implants
- Yes No j) Infertility
- Yes No k) Miscarriage within the last 12 months
- Yes No l) Abnormal Pap test
- Yes No m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months
- Yes No n) Genital warts
- Yes No o) Syphilis
- Yes No p) Gonorrhea
- Yes No q) Other sexually transmitted disease
- Yes No r) In vitro fertilization
- Yes No s) Heavy periods (menstruation) causing low blood iron
- Yes No t) Gender identity (role) disorder
- Yes No u) A female reproductive or genital disorder not listed above

17. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any digestive system disorders?

- Yes No a) Ulcerative colitis or Crohn's disease
- Yes No b) Gastrointestinal bleeding
- Yes No c) Gastrointestinal polyps
- Yes No d) Unrepaired cystocele or rectocele
- Yes No e) Gallstones and gallbladder has not been removed
- Yes No f) Hepatitis A, B, C, or other, currently under treatment
- Yes No g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)
- Yes No h) Cirrhosis
- Yes No i) Hepatitis A, fully recovered with no symptoms and normal liver function tests
- Yes No j) Other liver condition
- Yes No k) A digestive system disorder not listed above

(Medical questionnaire continues on page 10.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

18. **Within the last 5 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any urinary tract disorders?

- Yes No a) Chronic kidney failure
- Yes No b) Nephrotic syndrome
- Yes No c) Polycystic kidneys
- Yes No d) Kidney failure
- Yes No e) Chronic kidney infections (more than 2 per year)
- Yes No f) Kidney infection, resolved with no further treatment required
- Yes No g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests
- Yes No h) Kidney removed with a recommendation for further treatment
- Yes No i) Kidney stones, currently
- Yes No j) Kidney stones within the last 24 months
- Yes No k) Interstitial cystitis
- Yes No l) A kidney or urinary tract disorder not listed above

19. **Within the last 5 years**, has a medical professional advised you (or anyone you are applying for) that any of you have any abnormal lab results?

- Yes No

(If Yes, please list with patient's name[s], name[s] of test[s], result[s], and date[s] on page 13.)

20. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any blood or circulatory system disorders?

- Yes No a) Stroke
- Yes No b) Transient ischemic attacks (TIA)
- Yes No c) Hemophilia
- Yes No d) Thalassemia major
- Yes No e) Von Willebrand's disease
- Yes No f) Other blood disorder
- Yes No g) Blood pressure over 150/90
- Yes No h) Currently taking 3 or more medications for hypertension
- Yes No i) Hypertension under control with medication
- Yes No j) A blood or circulatory system disorder not listed above

21. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any cancer?

- Yes No a) Any cancer with lymph node involvement or metastasis (spread to other tissue)
- Yes No b) Cancer of the brain, breast, blood, pancreas, prostate, urinary bladder, or esophagus; or myeloma, Kaposi's sarcoma, or non-Hodgkin's lymphoma
- Yes No c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended
- Yes No d) Cancer of the colon, kidney, liver, lung, ovary, or stomach
- Yes No e) Skin cancer that has not been removed and requires further treatment
- Yes No f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended
- Yes No g) Melanoma
- Yes No h) A cancer not listed above

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

22. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?

Yes No

23. **Within the last 10 years**, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any psychological or mental health disorders?

- Yes No a) Mild depression/anxiety
 Yes No b) Major depression or neurosis
 Yes No c) Situational stress, anxiety, or depression no longer requiring treatment or medication
 Yes No d) Eating disorder (anorexia nervosa or bulimia)
 Yes No e) Suicide attempt
 Yes No f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia
 Yes No g) Hospitalization for a mental health condition
 Yes No h) A psychological or mental health condition not listed above

24. Are you (or anyone you are applying for) **regularly** taking any prescription medications?

Yes No

(If Yes, please list the person's name, the medication[s], the dosage, frequency, name/address/phone number of the prescribing medical professional, and the reason the person is taking this medication on page 13.)

25. Do you (or anyone you are applying for) drink alcoholic beverages?

Yes No

If Yes, please indicate how much you (or anyone you are applying for) drink **per week** and provide his or her name: _____

- Yes No a) Beer: _____ bottles/cans
 Yes No b) Wine: _____ glass
 Yes No c) Hard liquor: _____ glass

On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.

(If more than one person drinks, please list separately on page 13 the person's name and the amount consumed, using the format above.)

26. Are you (or anyone you are applying for) **currently** pregnant or an expectant father? Or, do you (or anyone you are applying for) **expect to be providing** medical insurance coverage for a newborn or new adoptee within the next 9 months?

Yes No

27. Do you (or anyone you are applying for) plan to be a surrogate parent (mother or father) **within the next year** or to engage someone to provide that service **within the next year**?

Yes No

(Medical questionnaire continues on page 12.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

28. For females age 11 and older:

Please answer the questions below and provide your name: _____

- Yes No a) Have you ever menstruated?
- Yes No b) Are your menstrual periods regular? (If you answered No, please explain on page 13.)
- Yes No c) Are you still having regular menstrual periods? (If you answered Yes, please indicate the date you started your last normal menstrual period on page 13.)

(If this question pertains to more than one family member, please list additional name[s] and answers on page 13, using the format above.)

29. Have you (or anyone you are applying for) been treated for, or advised that you have, a medical or health-related condition which you haven't indicated on this Medical Questionnaire? If so, please provide the appropriate details on the chart on page 13.

- Yes No

V Broker/Agent Information

FOR APPLICANTS USING AN INSURANCE BROKER/AGENT

I understand that the broker of record may receive monetary and/or non-monetary payments from Kaiser Foundation Health Plan of Ohio in connection with the purchase of this health plan coverage.

Note: Premiums are the same whether or not you use a broker/agent.

Name of broker/agent (please print)

Kaiser Permanente broker/agent ID #

Phone

E-mail address

Name of general agency

Kaiser Permanente general agency ID #

VI Billing Information

Application must be accompanied by payment information for your initial premium. The first month's payment must be by credit or debit card only. (After the first month, you can pay your premiums by check, money order, electronic funds transfer, or credit card. You will receive further information about payment choices for ongoing payments.) Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

Mr. Mrs. Ms. Miss Dr.

Last name

First name

MI

Street address

Apt./Unit #

City

State

ZIP

2. Credit/Debit card information: Credit Debit

Visa

Discover

MasterCard

American Express

Name as it appears on card

Credit/Debit card number

Credit/Debit card security number (Usually this is a three- or four-digit code on the back of the card near the signature line. In some cases it may be on the front of the card.)

Expiration date

Note: Premiums for enrollments beginning on the 15th of the month will be prorated for that month only, after which the standard billing cycle (1st of the month) will apply.

(This page is intentionally left blank.)

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.

VII 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 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 IX, page 19).

X

Primary applicant **Today's date**

X

Spouse **Today's date**

X

Dependent (age 18 or over) **Today's date**

X

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 (primary applicant, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. **Use ink only.**

VIII Authorization to Obtain or Release Medical Information
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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, 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 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 denied; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the coverage.

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*.

X	_____
Primary applicant	Today's date

X	_____
Spouse	Today's date

X	_____
Dependent (age 13 or over)	Today's date

X	_____
Dependent (age 13 or over)	Today's date

X	_____
Dependent (age 13 or over)	Today's date

X	_____
Dependent (age 13 or over)	Today's date

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

IX 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.

**Submit your completed application to:
Plans for Individuals and Families, Kaiser Permanente,
P.O. Box 7104, Pasadena, CA 91109-9835**

X HIPAA

If you do not qualify for Kaiser Permanente for Individuals and Families, you may be eligible for HIPAA coverage. 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 below. If all five statements below are true, you may be eligible for HIPAA coverage. For eligibility rules, rate, and benefit information, see the HIPAA section of the enrollment booklet. For questions about HIPAA or to request an enrollment application, call **1-800-524-7371, ext. 5613.**

HIPAA Eligibility Requirements

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.

By signing below, I understand that if I am denied Kaiser Permanente for Individuals and Families coverage and I wish to enroll in a HIPAA plan, I must call 1-800-524-7371, ext. 5613 to obtain a HIPAA enrollment application.

X _____
Primary Applicant **Today's date**

<i>For office use only:</i>	
<input type="checkbox"/> Accept <input type="checkbox"/> Deny <input type="checkbox"/> Rate <input type="checkbox"/> Alternate	Receive date: _____ Process date: _____
Effective date: _____	MRN/HRN listed in Section III, page 3
Purch-EU/Grp-Sbgrp: _____	