KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If someone in your family wants a different health plan, they must complete a separate application.
- To be eligible for KPIF coverage, you must live in our Georgia service area.

Who should not use this application?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You can apply for coverage at **buykp.org/apply**.
- To make changes to your existing KPIF account, call **1-888-865-5813** (TTY **711**).

Things to remember

- If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** for instructions.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- Remember, enrolling in a new plan won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts.
- **To make sure your application is processed in time and isn't canceled,** please return every page of the application, completed, with all the required signatures, and proof of your qualifying life event (if required). Send these materials by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23127
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-855-355-5334**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-494-5314** (TTY **711**).
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call them for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305.

Primary applicant

STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Child support order or other court order to cover a dependent
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Determination by the health benefit exchange of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution to COBRA premium

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.

STEP 2: Choose your health plan

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

Bronze

- ☐ KP GA Bronze Virtual Complete 5500 Ded/1500 Rx Ded
  KP GA Signature Bronze Virtual Complete 5500/1500 RxDed†
- ☐ KP GA Bronze 6500/40%/HSA
  KP GA Signature Bronze 6500/40%/HSA†
- ☐ KP GA Standard Bronze 7500/50
  KP GA Signature Standard Bronze 7500/50†

Silver

- ☐ KP GA Silver 3400 Ded/500 Rx Ded
  KP GA Signature Silver 3400 Ded/500 Rx Ded†
- ☐ KP GA Silver 4500/35
  KP GA Signature Silver 4500/35†
- ☐ KP GA Standard Silver 5900/40
  KP GA Signature Standard Silver 5900/40†
- ☐ KP GA Silver Virtual Complete 5000
  KP GA Signature Silver Virtual Complete 5000†
- ☐ KP GA Silver Virtual Complete 5500
  KP GA Signature Silver Virtual Complete 5500†

Gold

- ☐ KP GA Gold 500 Ded/500 Rx Ded
  KP GA Signature Gold 500 Ded/500 Rx Ded†
- ☐ KP GA Gold 1500 Ded/500 Rx Ded
  KP GA Signature Gold 1500 Ded/500 Rx Ded†
- ☐ KP GA Gold 2000 Ded/500 Rx Ded
  KP GA Signature Gold 2000 Ded/500 Rx Ded†
- ☐ KP GA Standard Gold 1500/30
  KP GA Signature Standard Gold 1500/30†

For applicants under 30 or with hardship exemptions

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

- ☐ KP GA Catastrophic 9450
  KP GA Signature Catastrophic 9450†

†If you live in Clayton, Cobb, DeKalb, Fulton, Gwinnett, or Henry counties, your plan will be in the KP Signature HMO network. Please see the KPIF Enrollment Guide for important information on plans with the KP Signature HMO network.

To request a copy of the *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-888-865-5813** (TTY **711**), or contact your broker.

Primary applicant

STEP 3: 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 18, the child is the primary applicant.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Home address (no P.O. boxes, please)

City

State | ZIP code | County | Phone (mobile phone if available)

Mailing address ☐ Check if same as home address.

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Parent or legal guardian

Please complete this section if the primary applicant is a child under 18. The parent or legal guardian must be 18 or older.

First name | MI

Last name

Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) | Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English) | Preferred language read (if not English)

Primary applicant

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by the state of Georgia.

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy) / /

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? ☐ Yes ☐ No
Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name | MI | Date of birth (mm/dd/yyyy) / /

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? ☐ Yes ☐ No
Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

2 First name | MI | Date of birth (mm/dd/yyyy) / /

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? ☐ Yes ☐ No
Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

Primary applicant

3 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

STEP 4: 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 only. This person is called an authorized representative.

First name | MI

Last name | Phone (mobile phone if available)

By signing, you've 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.

X | Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

STEP 5: Sign the application agreement

Important: The primary applicant must read, sign, and date below. If the primary applicant is a child under 18, then their 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. A copy of your agreement with your signature is as valid as the original. If your signature is missing, we will cancel the application. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- If I worked with a broker, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the broker or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- 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.
- By providing my email address and mobile phone number, I am agreeing to receive email and text communications from Kaiser Permanente.

X | Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

Primary applicant

STEP 6: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options (choose one) ☐ Electronic payment ☐ Check ☐ Money order ☐ Credit card ☐ Debit card

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's payment amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

To pay with a credit or debit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

Primary applicant

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call Member Services at **1-888-865-5813** (TTY **711**).

Do you want to sign up for automatic monthly payments?

- ☐ Yes
  - ☐ I want to enter a new payment method here. (Please fill out this page.)
  - ☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)
- ☐ No, I don't want automatic monthly payments. (Skip this page)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Automatic payment options (choose one)

☐ Electronic payment ☐ Credit card (debit cards can't be used)

If electronic payment, select account type: ☐ Checking account ☐ Savings account

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

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

To pay with a credit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

Primary applicant

For applicants using a broker or Kaiser Permanente representative

If a broker or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The broker may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Our standard compensation is $28, per member per month, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

Note: Premiums are the same whether or not you use a broker or Kaiser Permanente representative.

To be completed by your broker or representative after you complete this application:

Agency name

Agency ID number

Broker or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone (mobile phone if available)

Fax

Email address

I (the broker/Kaiser Permanente representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the *Evidence of Coverage* except through written materials furnished by Kaiser Foundation Health Plan of Georgia, Inc. The applicant has been informed that the effective date of coverage is assigned by Kaiser Foundation Health Plan of Georgia, Inc. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

☐ Yes ☐ No

X

Broker or Kaiser Permanente representative

Date (mm/dd/yyyy)

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-888-865-5813** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-865-5813**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-888-865-5813** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

日本語 (Japanese) 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-865-5813**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-865-5813** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-865-5813** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-888-865-5813** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-865-5813** (TTY: **711**).

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KAISER PERMANENTE®