Georgia

MID GROUP EMPLOYEE ENROLLMENT FORM WITH MEDICAL REVIEW

(FOR GROUPS 51 OR MORE ELIGIBLE EMPLOYEES)

The information requested on this application is necessary for purposes of processing your request for group coverage, and verifying the appropriateness of final rates.

Please Note: Statements made in application form are deemed representations and are not warranties.

Effective date ______/______/______

CHECK PLAN TYPE:

- ❑ HMO
- ❑ Multi-Choice (For Renewals Only)
- ❑ HSA - Qualified Deductible HMO (Self Only)
- ❑ Deductible Plan with HRA (Self Only)
- ❑ Consumer Choice Option (CCO)
- ❑ HSA - Qualified Deductible HMO (Family)
- ❑ Deductible Plan with HRA (Family)
- ❑ Out-of-Area (For Renewals Only)
- ❑ Added Choice (For Renewals Only)
- ❑ Dual Choice PPO

CHECK ENROLLMENT TYPE:	FILL OUT SECTIONS:
❑ New Enrollment for Groups of 51-99 employees (including COBRA enrollment)	A,B,C,D (if applicable), & E
❑ Waive Coverage	A & D

TO BE COMPLETED BY EMPLOYER:

Effective Date ________ Group Number ________ Sub Group ________ Bill Group ________

Note: Please print and use blue or black ink.

Language Preference ____________________

A EMPLOYER INFORMATION

Last Name		First Name	MI	Gender ❑ Male ❑ Female
Date of Birth	Social Security Number	E-mail Address (optional)	Ethnicity (optional)	
Address		City	State	Zip Code
Home Phone	Job Title	Height Weight	Marital Status ❑ Married ❑ Single	
Please select Primary Care Physician	Physician ID #	Check if you are an existing patient. ❑		
Company Name		Date of Employment	Hours Worked	
Employment Status ❑ Active ❑ Retired ❑ Disabled ❑ COBRA Consumer Choice Option (CCO) ❑ Yes ❑ No *If yes, an additional premium will apply.*		Are you an independent contractor? ❑ Yes ❑ No		

Kaiser Permanente Insurance Company (KPIC)
Kaiser Foundation Health Plan of Georgia, Inc.

B COVERAGE STATUS

❑ Self Only ❑ Self + Spouse ❑ Self + Spouse + Child(ren) ❑ Self + Child(ren)

Spouse Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	

Dependent 1 Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	
College Student? ❑ Yes ❑ No	School			Disabled? ❑ Yes ❑ No	

Dependent 2 Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	
College Student? ❑ Yes ❑ No	School			Disabled? ❑ Yes ❑ No	

Dependent 3 Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	
College Student? ❑ Yes ❑ No	School			Disabled? ❑ Yes ❑ No	

Dependent 4 Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	
College Student? ❑ Yes ❑ No	School			Disabled? ❑ Yes ❑ No	

Dependent 5 Last Name		First Name		MI	Height Weight
Date of Birth	Gender ❑ Male ❑ Female	Social Security Number	Physician ID #	Check if you are an existing patient. ❑	
College Student? ❑ Yes ❑ No	School			Disabled? ❑ Yes ❑ No	

C HEALTH QUESTIONNAIRE

1. During the past 12 months, have you or any dependent to be covered, discussed, been advised, or recommended to have treatment or surgery which has not been completed or are taking or been prescribed prescription medication?

   ❑ Yes ❑ No

2. In the past 3 years have you or any dependent to be covered been diagnosed with, been seen, or treated for any of the following conditions? ❑ Yes ❑ No (If answered "Yes", check all of the following that apply.)

   ❑ Acquired Immune Deficiency Syndrome (AIDS)
   ❑ Human Immunodeficiency Virus (HIV) infection
   ❑ Alcohol or drug abuse
   ❑ Rheumatoid Arthritis
   ❑ Disorders of the back, neck, or spine
   ❑ Heart disease/disorder
   ❑ Stroke or vascular disease/disorders
   ❑ Lung disorders
   ❑ Insulin dependent diabetes
   ❑ Stomach or intestinal Disorder
   ❑ Cancer or tumors
   ❑ Blood disorder
   ❑ Kidney or liver disease/disorder

3. Are you or any dependent to be covered currently pregnant or an expectant parent? ❑ Yes ❑ No

If you answered "Yes" to any of the above questions, provide details below.
If additional space is needed attach a separate sheet and provide the same information requested below.

Question #	Name of Applicant	Exact Diagnosis	Date Diagnosed	Date Last Treated
Provide Details Regarding Treatment				

Hospitalized? ❑ Yes ❑ No	Further Treatment Recommended? ❑ Yes ❑ No	Degree of Recovery		Date Last Treated
Medication Prescribed? ❑ Yes ❑ No	Name of Medication	Dosage	Times per Day	Date Last Filled
	Name of Medication	Dosage	Times per Day	Date Last Filled
	Name of Medication	Dosage	Times per Day	Date Last Filled

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	Name of Medication	Dosage	Times per Day	Date Last Filled
	Name of Medication	Dosage	Times per Day	Date Last Filled

D WAIVER OF COVERAGE/OTHER COVERAGE INFORMATION

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer.

I refuse the following: ❑ All coverage ❑ Coverage for my spouse ❑ Coverage for my children

Reason for refusal: (Please check all appropriate boxes)

❑ Other group coverage sponsored by my employer

❑ Other group coverage sponsored by my spouse's employer

❑ Other group coverage sponsored by another organization

❑ Other reason (please explain) ______________

____

____

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit an Employee Enrollment Form and coverage may be subject to late enrollee provisions, as allowed by law.

Do you or any dependents have any other medical insurance? (check one) ❑ Yes ❑ No

Do you or any dependents currently receive Medicare benefits? (check one) ❑ Yes ❑ No

Insurance Company Name ______________________________

Policy Number ______________________________

Insurance Company Address ______________________________

Policy Holder ______________________________

City ____________________ State ______ Zip Code __________

Policy Holder Date of Birth ______ - _____ - ______

E SIGNATURE

Please complete this application and submit it to your company's Benefits Administrator. I understand and agree that if the application is accepted by Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, my spouse, and dependents (if any) will be eligible will be in accordance with the Group Agreement and/or Group Policy, as applicable to the type of plan for which we are enrolled. I further understand and agree that I, my spouse, and dependents (if any) will be bound by the terms and conditions of such agreements. I authorize the deduction from my wages, amounts necessary to pay the employee portion of the premiums for my, my spouse's, and covered dependents' (if any) Health Plan and/or KPIC, as applicable, coverage. I understand that to be eligible for coverage and remain eligible, I must satisfy the eligibility requirements set forth in my employer's agreement with Health Plan, and that the information provided in this application may be relied on and used to determine my, my spouse's, and my dependents' (if any) eligibility for such coverage.

I agree to provide any documentation, including tax returns, payroll records, etc. necessary to establish that I, my spouse, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:

   a. The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.

   b. For non-grandfathered health plans, any dependent child of the subscriber or the subscriber's spouse can be covered until the age of 26. For grandfathered health plans, any dependent child of the subscriber or the subscriber's spouse can be covered until the age of 26 if such child does not have access to their own employer sponsored coverage.

2. Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Evidence of Coverage*.

3. Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.

4. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Member Services at **404-261-2590** before signing this application.

Personal Information

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Heath Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy.

I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Heath Plan of Georgia, Inc., Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, Georgia 30305.

NOTICES:

1. I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the rescission of my coverage, as well as the coverage of my spouse and covered dependents (if any), without liability to Health Plan and/or KPIC, as applicable, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.
2. You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, GA 30305.
3. This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at *kp.org*. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Member Services at **404-261-2590**.
4. HMO plans and the Kaiser Permanente Select Provider benefit level of the POS plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the POS plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company

IMPORTANT: Please read the conditions above, and sign and date below. All applications MUST be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

____ ____________

Signature of Employee Date

© 2018 Kaiser Foundation Health Plan of Georgia, Inc.

Non-Discrimination

Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company, Inc. (KPIC), individually and collectively, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Neither Health Plan nor KPIC exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Health Plan and KPIC, as applicable, also:

- Provide no cost aids and services to people with disabilities to communicate effectively with them, 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 either Health Plan or KPIC 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 ሊያግዝዎት 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**).

ગજુરાતી (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'dę́ę́', t'áá jiik'eh, éí ná hóló̜, koji̜' 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**).