KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street, Rockville, Maryland 20852

KAISER PERMANENTE APPLICATION FOR INCAPACITATED DEPENDENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative before signing this application or card.

1. Dependent information to be completed by subscriber

☐ Dependent ☐ Other _____ ☐ Male ☐ Female

LAST NAME | FIRST NAME | MI | SUFFIX

DATE OF BIRTH (MM/DD/YYYY) | MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan) | GROUP NUMBER

Does dependent live with parent(s)? ☐ Yes ☐ No

ADDRESS | APARTMENT NUMBER

CITY | COUNTY | STATE | ZIP CODE

DAY TIME PHONE (111-222-3333) | EVENING PHONE (111-222-3333)

Dependent's marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

EMAIL ADDRESS (OPTIONAL)

Is dependent entitled to other insurance? ☐ Yes (If yes, please check applicable boxes below.) ☐ No

☐ Medicaid ☐ Medicare ☐ Other _____

Is dependent employed? ☐ Yes ☐ No

EMPLOYER | EMPLOYER ADDRESS

APPLICANT SIGNATURE | DATE

2. Subscriber information

SUBSCRIBER LAST NAME | SUBSCRIBER FIRST NAME | MI | SUFFIX

MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan) | GROUP NUMBER

SPOUSE LAST NAME | SPOUSE FIRST NAME | MI | SUFFIX

ADDRESS | APARTMENT NUMBER

CITY | COUNTY | STATE | ZIP CODE

DAY TIME PHONE (111-222-3333) | EVENING PHONE (111-222-3333)

EMPLOYER | EMPLOYER ADDRESS

Does your dependent qualify as your tax deduction? ☐ Yes ☐ No

3. To be completed by dependent's physician

In your opinion, will dependent ever be capable of self-sustaining employment? ◯ Yes ☐ No

Disability: ☐ Temporary ☐ Continuing Disability likely to improve? ☐ Yes ☐ No

Is dependent presently incapable of self-sustaining employment because of? ☐ Mental incapacity ☐ Physical handicap

Date disability occurred (MM/DD/YYYY):

Diagnosis of condition causing disabled status and description of limitations:

Physician's comments:

APPLICANT SIGNATURE | DATE (MM/DD/YYYY)

FACILITY | FACILITY ADDRESS

4. To be completed by review committee

Coverage ☐ Accepted, how long? _____

☐ Rejected, reason:

DATE REVIEWED (MM/DD/YYYY) _____

PHYSICIAN'S LAST NAME | PHYSICIAN'S FIRST NAME | MI | SUFFIX

PHYSICIAN'S SIGNATURE

AUTHORIZED SIGNATURE | DATE REVIEWED (MM/DD/YYYY)

DATE MEMBER NOTIFIED (MM/DD/YYYY) _____ ☐ TELEPHONE ☐ LETTER

DATE FORWARDED TO MEMBERSHIP ADMINISTRATION _____