Enrolling is Simple.
Just Follow These 2 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: **877-447-4999** fax: **818-500-1855**

Step 2

SEND THE COMPLETED APPLICATION TO:

First Eagle Insurance Services
333 S. Central Ave., Ste. 101
Glendale, CA 91204

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 877-447-4999

Thank you for choosing...

KAISER PERMANENTE

KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: Use this form to apply for individual coverage provided by Kaiser Permanente for Individuals and Families (KPIF), a business unit of Kaiser Foundation Health Plan, Inc. 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 1-800-494-5314. Or, if you are working with a broker, please call him or her for assistance. We will provide translation services and other language assistance free of charge if you need it. Each family member applying for coverage will need to fill out a separate application.

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

Mail your completed application to:
Kaiser Permanente for Individuals and Families
P.O. Box 7104
Pasadena, CA 91109
Or send it by secure fax to **1-866-816-5139**.

I Applicant to Be Covered

Last name

First name MI

Street address Apt./Unit #

City State ZIP

( ) ☐ Day ☐ Evening
Home phone

( ) ☐ Day ☐ Evening
Work phone

Email address

How do you prefer to be contacted? ☐ Email ☐ U.S. mail

Primary spoken language:

☐ English ☐ Other (Please specify.) _____

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)

II Financially Responsible Party/Parent/Guardian

If the financially responsible party is someone other than the Applicant, please complete the information below.

Last name

First name MI

Street address Apt./Unit #

City State ZIP

( ) ☐ Day ☐ Evening
Home phone

( ) ☐ Day ☐ Evening
Work phone

Email address

Date of birth M/F

Primary spoken language:

☐ English ☐ Other (Please specify.) _____

III Account Information

If you are already a Kaiser Permanente for Individuals and Families (KPIF) member, please answer the next two questions and check all boxes that apply. If you are not a KPIF member and would like to apply for new coverage, please skip to question 3.

1. **Are you adding a family member or dependent to your existing KPIF family plan coverage that became effective prior to January 1, 2011? If accepted, your family member will be added to your existing plan.**

   ☐ Yes ☐ No

   If you answered *Yes*, please provide your medical record number and plan name in the space below and skip to question 5.
   Medical record number and plan name of your existing KPIF family plan _____

2. **Are you switching plan/coverage from an existing KPIF plan?**

   ☐ Yes ☐ No

   If you answered *Yes*, please provide your medical record number and plan name in the space below and proceed to question 3.
   Medical record number and plan name of your existing KPIF plan _____

3. **Which plan would you like to apply for? (Select only one plan.)**[1]

☐ Copayment 25	☐ Deductible 20/500	☐ Deductible 0/1500 with HSA
☐ Copayment 40	☐ Deductible 25/1000	☐ Deductible 0/2700 with HSA
☐ Copayment 50	☐ Deductible 30/1500	☐ Deductible 30/2700 with HSA
	☐ Deductible 40/2000	☐ Deductible 40/4000 with HSA
	☐ Deductible 40/3000	☐ Deductible 50/5000 with HSA

4. **Are you applying for the optional dental plan?**

   ☐ Yes, I would like to enroll in the Dental Insurance Plan, which is administered by Delta Dental of California and underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

   ☐ No

5. **Effective date:**

   For adults age 19 and over: Please check your desired effective date, if you are approved.

   ☐ 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.)

   For children under age 19: Applications received by the 15th of the month are effective on the 1st of the next month.
   Applications received on the 16th and later are effective on the 1st of the month after the next.

   We will notify you of your effective date in your acceptance letter, if we approve your application. We will do our best to honor your desired effective date. If for some reason there is a delay in processing your application, we will select the next available effective date.

Note: All applications must be accompanied by a credit/debit card payment for the first month's premium. Please make certain that you have provided the necessary information on page 17 of this application. 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.

(continues on page 3)

[1]For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* for a particular plan, please call us at 1-800-634-4579 or contact your broker.

III Account Information *(continued)*

You may not qualify for the plan you request at the standard rate. However, you may qualify for that plan at a higher rate or for a different plan. If so, we will enroll you in the requested plan at the higher rate, or the closest plan for which you qualify. We will notify you of the plan and rate with your acceptance letter. You may cancel your enrollment without financial penalty.

If you do not qualify for any KPIF plan, you may qualify for a HIPAA plan without medical review. Please review and complete Section XI, "HIPAA Eligibility Requirements and Enrollment Information," on pages 23–24.

IV Prior Coverage Information

Provide the information below for the Applicant's current or most recent health coverage provider and primary care physician. Failure to provide physician information will significantly delay processing of your application.

Previous Kaiser Permanente member

Is the Applicant an existing or former Kaiser Permanente member?

☐ Yes ☐ No

If *Yes*, please provide the following information:

Existing or former medical record number _____

Termination date, if applicable _____

Prior health coverage provider

Did the applicant have health coverage within the last 63 days?

☐ Yes ☐ No

If *Yes*, please provide the following information:

Type of coverage: ☐ COBRA ☐ Group/Employer ☐ Individual ☐ Other

Health coverage provider _____

Policy ID _____

Start date of coverage _____

End date of coverage _____

Most recent primary care physician

Is the Applicant a current patient of this physician?

☐ Yes ☐ No

Physician name _____

Street address _____

City, state, ZIP _____

Phone number _____

Date of last visit _____

V 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 covered by Kaiser Permanente for Individuals and Families (KPIF). **Each Applicant for KPIF coverage must undergo medical review regardless of current or previous KPIF coverage.** Omissions or incomplete answers regarding the Applicant's health history will delay processing of the application. **Either intentional or willful misrepresentation of an Applicant's health history can result in rescission of coverage for that Applicant (see Section IX for details).**

This application becomes part of the Applicant's Kaiser Permanente record. If you need assistance completing this medical questionnaire, you may call us toll free at **1-800-494-5314**, or you may call your broker. Kaiser Permanente does not discriminate in its decision-making based on: age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information.

You must answer each question and subquestion. Please answer *Yes, No,* or *Not sure (NS)* to each question. (*You* in the questionnaire refers to the Applicant.) Mark *Not sure (NS)* only if you do not understand the question being asked, do not understand the medical terms being used, do not know if you have or have had this condition, cannot remember when you had the condition listed, don't remember the date that you consulted a physician or were admitted to a hospital, or don't remember the information that you need to provide in order to answer the question correctly. Each question for which you answer *Yes* or *Not sure (NS)* requires an explanation. Please see the charts on pages 12–15 and provide the information requested. We may need to contact you for further explanation if you answered *Yes* or *Not sure* to any questions.

If you need help completing this application, please call 1-800-494-5314. Or, if you are working with a broker, please contact him or her for assistance.

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

2. **Office visits:** ***Within the last 12 months***, have you sought advice or treatment from a medical professional's office?
   ☐ Yes ☐ No ☐ NS a) Physical exam
   ☐ Yes ☐ No ☐ NS 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 ☐ NS c) Chiropractic visits
   ☐ Yes ☐ No ☐ NS d) Prenatal care
   ☐ Yes ☐ No ☐ NS e) Psychological counseling
   ☐ Yes ☐ No ☐ NS f) Medication management
   ☐ Yes ☐ No ☐ NS g) A reason not listed above

3. **Pending treatment:** ***Within the last 3 years***, have you 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 ☐ NS

4. **Substance abuse treatment:** ***Within the last 3 years***, have you been instructed to attend, attended, or participated in a program that deals with ***your*** alcohol or substance abuse?
   ☐ Yes ☐ No ☐ NS

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

5. **Skin/Dermatological:** ***Within the last 3 years***, have you been treated for, or has a medical professional advised you that you have, any skin/dermatological disorders?
   - ☐ Yes ☐ No ☐ NS a) Acne
   - ☐ Yes ☐ No ☐ NS b) Psoriasis
   - ☐ Yes ☐ No ☐ NS c) Burns
   - ☐ Yes ☐ No ☐ NS d) Keloids requiring plastic surgery
   - ☐ Yes ☐ No ☐ NS e) Cosmetic or reconstructive surgeries, revisions
   - ☐ Yes ☐ No ☐ NS f) A skin or dermatological condition not listed above

6. **Eyes/Ears/Nose/Throat:** ***Within the last 3 years***, have you been treated for, or has a medical professional advised you that you have, any disorders of the eyes, ears, nose, or throat?
   - ☐ Yes ☐ No ☐ NS a) Glaucoma
   - ☐ Yes ☐ No ☐ NS b) Cataracts, cataract surgery for one or both eyes
   - ☐ Yes ☐ No ☐ NS c) Crossed eyes
   - ☐ Yes ☐ No ☐ NS d) Detached retina
   - ☐ Yes ☐ No ☐ NS e) Macular degeneration
   - ☐ Yes ☐ No ☐ NS f) Deviated septum
   - ☐ Yes ☐ No ☐ NS g) Sleep apnea, chronic snoring, or unresolved insomnia
   - ☐ Yes ☐ No ☐ NS h) Nasal and/or throat polyps
   - ☐ Yes ☐ No ☐ NS i) A condition of the eyes, ears, nose, or throat not listed above

7. **Tobacco history:** Have you ever used tobacco, including snuff and chewing or other smokeless tobacco?
   - ☐ Yes ☐ No ☐ NS
     - a) If *Yes*, how many years? _____
   - ☐ Yes ☐ No ☐ NS b) Have you stopped using tobacco products?
     - c) If *Yes*, how many years ago did you quit? _____
     - d) If you smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:
       Cigarettes: ____ packs per day
       Pipes: _____ bowls per day
       Cigars: _____ per day

8. **Illegal drugs:** ***Within the last 5 years***, have you taken or used illegal drugs or prescription drugs not prescribed by a medical professional?
   - ☐ Yes ☐ No ☐ NS

9. **Nervous system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any brain, neurological, or nervous disorder?
   - ☐ Yes ☐ No ☐ NS a) Multiple sclerosis
   - ☐ Yes ☐ No ☐ NS b) Autism
   - ☐ Yes ☐ No ☐ NS c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
   - ☐ Yes ☐ No ☐ NS d) Seizures treated with more than 2 medications for control
   - ☐ Yes ☐ No ☐ NS e) Seizures under control with 2 or fewer medications
   - ☐ Yes ☐ No ☐ NS f) Most recent seizure within the last 12 months
   - ☐ Yes ☐ No ☐ NS g) Alzheimer's disease
   - ☐ Yes ☐ No ☐ NS h) A brain, neurological, or nervous disorder not listed above

(Medical questionnaire continues on page 6.)

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

10. **Cardiovascular system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any heart or cardiovascular disorders?

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

11. **Respiratory system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any respiratory disorders?

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

12. **Musculoskeletal system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any muscle or bone disorders?

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

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

13. **Metabolic/Endocrine system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any metabolic or endocrine (hormone) disorders?

☐ Yes ☐ No ☐ NS a) AIDS

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

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

14. **Congenital/Developmental:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any congenital defects or developmental disorders?

☐ Yes ☐ No ☐ NS a) Down syndrome
☐ Yes ☐ No ☐ NS b) Cerebral palsy
☐ Yes ☐ No ☐ NS c) Cleft palate or lip
☐ Yes ☐ No ☐ NS d) Club foot
☐ Yes ☐ No ☐ NS e) Congenital heart defect (specify type on pages 12–15)
☐ Yes ☐ No ☐ NS f) Developmental delay
☐ Yes ☐ No ☐ NS g) Prematurity (for children up to 2 years old)
☐ Yes ☐ No ☐ NS h) A neurological or physical abnormality not listed above (specify on pages 12–15)

15. **For males:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any of the following:

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

(Medical questionnaire continues on page 8.)

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

16. **For females:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any of the following:

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

17. **Digestive system:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any digestive system disorders?

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

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

18. **Urinary tract:** ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any urinary tract disorders?

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

19. **Lab results:** ***Within the last 5 years***, has a medical professional advised you that you have any abnormal lab results?

☐ Yes ☐ No ☐ NS

If *Yes*, please provide the names of tests, results, and dates on pages 12–15.

20. **Circulatory system:** ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any blood or circulatory system disorders?

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

21. **Cancer:** ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any cancer?

- ☐ Yes ☐ No ☐ NS a) Any cancer with lymph node involvement or metastasis (spread to other tissue)
- ☐ Yes ☐ No ☐ NS 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 ☐ NS c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended
- ☐ Yes ☐ No ☐ NS d) Cancer of the colon, kidney, liver, lung, ovary, or stomach
- ☐ Yes ☐ No ☐ NS e) Skin cancer that has not been removed and requires further treatment
- ☐ Yes ☐ No ☐ NS f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended
- ☐ Yes ☐ No ☐ NS g) Melanoma
- ☐ Yes ☐ No ☐ NS h) A cancer not listed above

(Medical questionnaire continues on page 10.)

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

22. **Prosthetics/Implants/Transplants:** ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?

☐ Yes ☐ No ☐ NS

23. **Mental health:** ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any psychological or mental health disorders?

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

24. **Prescriptions:** Are you taking any prescription medications?

☐ Yes ☐ No ☐ NS

If *Yes*, please enter prescription medication information in the chart below.

Name of prescription medication (Rx)	Reason for taking medication	Dosage/ Frequency	Rx start date	Rx end date	Name/Address/Phone number of prescribing medical professional

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

25. **Alcohol:** Do you drink alcoholic beverages?

☐ Yes ☐ No ☐ NS

If ***Yes***, please indicate how much you drink ***per week***:

a) Beer: _____ bottles/cans

b) Wine: _____ glasses

c) Hard liquor: _____ drinks

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

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

☐ Yes ☐ No ☐ NS

27. **Surrogacy:** Do you 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 ☐ NS

28. **For females age 11 and older:**

☐ Yes ☐ No ☐ NS a) Have you ever menstruated?

☐ Yes ☐ No ☐ NS b) Are your menstrual periods regular? (If you answered *No*, please explain on pages 12–15.)

☐ Yes ☐ No ☐ NS c) Are you still having regular menstrual periods? **(If you answered *Yes*, please indicate the date you started your last normal menstrual period on the charts on pages 12–15.)**

29. **Other:** ***Within the last 5 years***, have you been treated for, or advised that you have, a medical or health-related condition that you haven't indicated on this medical questionnaire? If so, please provide the appropriate details on the charts on pages 12–15.

☐ Yes ☐ No ☐ NS

(Medical questionnaire continues on page 12.)

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

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

____

____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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(Medical questionnaire continues on page 14.)

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

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
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- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of treating physician	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
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- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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VI Agent, Broker, and Representative Information

FOR APPLICANTS USING AN INSURANCE AGENT/BROKER/REPRESENTATIVE

Agent/Broker/Representative name _____

(*Representative* means any representative of Kaiser Permanente for Individuals and Families (KPIF) who has provided you with assistance.)

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.

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

TO BE COMPLETED BY YOUR KAISER PERMANENTE–APPOINTED AGENT/BROKER/REPRESENTATIVE AFTER COMPLETION OF THIS APPLICATION

Notice to agent, broker, representative: If you have assisted the Applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

You must answer the following question by selecting *Yes* or *No:*

I assisted the Applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant understood the explanation.

☐ Yes ☐ No

X _____

Agent/Broker/Representative signature (Use ink only.) **Today's date**

First Eagle, Inc.
Name of agent/broker/representative (Please print.)

Kaiser Permanente–appointed broker identification number

333 S. Central Ave., Ste. 101
Address

Glendale | CA | 91204
City | State | ZIP

877-447-4999 | 818-500-1855
Phone | Fax

vic@hiplans.com
Email address

VII Billing Information

Application must be accompanied by payment information for your initial premium. 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

Cardholder's name as it appears on card

Credit/Debit card number

Expiration date

(This page is intentionally left blank.)

VIII Authorization to Release Medical Information

All Applicants: Please read the following information and sign in the space(s) provided on the following page.

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, pharmacy benefit manager, or any other medical or medically related facility, health care provider, or professional who has provided any services to an *Applicant* (for purposes of Section VIII, *Applicant* is defined as me or any family member applying for or having membership in any KPIF product), or any entity that compiles *Medical Information* (defined as **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, or AIDS [acquired immune deficiency syndrome])** from any of these individuals or entities, to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's Medical Information. **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 to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected (except for any Applicant under the age of 19, who must be accepted under applicable law); if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for 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, AIDS-related information, and psychotherapy notes. Medical Information, once disclosed, may no longer be protected by federal privacy law and may be further disclosed. I understand that, under California law, the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

(continues on page 20)

VIII Authorization to Release Medical Information *(continued)*

This authorization is effective on the date that the Applicant signs the application 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 KPIF 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) 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*.

Important: required signatures (Use ink only.)

- An Applicant age 18 and over must sign and date on the appropriate signature line.
- An Applicant age 12–17 must sign and date on the appropriate signature line. (Minors have the right to control the release of certain types of medical history and records. We require that such minors sign in addition to their parents or legal guardians.)

If you are completing this application on behalf of your child, your signature as parent or legal guardian represents authorization for children under 12 years of age.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 12)

X _____

Applicant (age 12 or over) **Today's date**

IX Conditions of Acceptance

All Applicants or legal representatives of Applicants: Please read the following information and sign in the space(s) provided on page 21.

The Applicant must fully answer each question in this application even though he or she may already be a member in a KPIF plan. If we decide to accept the Applicant for KPIF membership, our decision will be based primarily on health information the Applicant provides in this application and during the enrollment process. If the Applicant has or has previously had coverage in any plan offered by Kaiser Foundation Health Plan or Kaiser Permanente Insurance Company (together, Kaiser Permanente), we will review the Applicant's prior health history with Kaiser Permanente before making our decision. In doing so, we may review the Applicant's use of health care services for up to a year following enrollment in KPIF to confirm that his or her actual health status at the time of acceptance in KPIF qualified the Applicant for enrollment in KPIF.

(continues on page 21)

IX Conditions of Acceptance *(continued)*

This form must be completed accurately. If there is uncertainty about the answer to any question, take the time to make sure the information is accurate before submitting it to us. By signing this application, the Applicant represents that all responses are true, complete, and accurate to the best of his or her knowledge, and that if the Applicant is accepted for enrollment in KPIF, this application will become part of the plan contract between the Applicant and Kaiser Permanente.

Our decision to accept the Applicant (any Applicant under the age of 19 must be accepted under applicable law) for coverage will be made only after we have thoroughly reviewed the medical history information disclosed in Section V of this application. Our review will include our reasonable efforts to verify the accuracy and completeness of the information disclosed in Section V. We are under a duty to complete this process of review and verification of Applicant health history information (medical review).

If we determine that the Applicant or someone on his or her behalf either intentionally or willfully gave us incomplete or incorrect material information about the current or past health of the Applicant (or if such intentional or willful misrepresentation of health history was made at any time during the enrollment process), and our decision to accept the enrollment was based on this misinformation, we may rescind membership. Additionally, if we determine that the Applicant or someone on his or her behalf lied about the Applicant's age or the nature of the Applicant's relationship to the person who is financially responsible for his or her coverage, and our decision to accept the Applicant's enrollment is based on this misinformation, we may rescind membership. This means that we would completely void KPIF membership of the misrepresenting individual as if no coverage had ever existed. If we approve the application for coverage for the Applicant without properly completing medical review, we may only rescind coverage if we can support a claim that health history information disclosed in Section V, or material health information not disclosed, was willfully misrepresented or omitted.

Before making any decision to rescind, we would notify the Applicant in writing why we believe we have grounds to rescind his or her coverage. Our notice will tell the Applicant why we believe his or her application may be inaccurate or incomplete and invite the Applicant to provide us with additional medical or other information to help us confirm his or her actual health status at the time the Applicant was accepted for enrollment. If, after considering the Applicant's response, we decide to rescind, we will send written notice to the Applicant at least 30 days before the date we rescind his or her coverage, explaining the basis for our decision and how the Applicant can appeal it. If the coverage is lawfully rescinded, the rescinded individual may have to reimburse us for the reasonable value of any services that we provided or that we paid for on his or her behalf, if legally permitted. If accepted for enrollment, the Applicant may refer to his or her KPIF *Membership Agreement* for more information about rescission of membership in KPIF. Within 30 days, we will refund all applicable premiums except that we may subtract any amounts the Applicant owes us.

All faxed and mailed correspondence must be signed and dated by the Applicant or someone legally authorized to act on his or her behalf. The Applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **1-800-634-4579**.

Important: Required signatures—all Applicants age 18 or over must sign and date below on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18. If signatures are not supplied, we cannot continue processing the application. **(Use ink only.)**

X _____

Applicant/Financially responsible party (signing on behalf of self or Applicant under the age of 18)

Today's date

X _____

Applicant (age 18 or over)

Today's date

☐☐☐ – ☐☐ – ☐☐☐☐

Applicant's Social Security number

☐☐☐ – ☐☐ – ☐☐☐☐

Financially responsible party's Social Security number (if financially responsible party is other than Applicant)

X Arbitration Agreement

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation [29 CFR 2560.503-1], certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement*.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 18)

X _____

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

For office use only:

Receive date: _____

t Accept t Reject t Rate t Alternate Process date: _____

Effective date: _____ MRN listed in Section IV, page 3

Purch-EU/Grp-Sbgrp: _____

XI HIPAA Eligibility Requirements and Enrollment Information

The Applicant 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 below.

If the Applicant does not pass medical review for KPIF plan coverage but meets all of the five requirements listed below, the Applicant is guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the plan for which the Applicant applied. If eligible, this document is the Applicant's offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll the Applicant in the applicable Kaiser Permanente HIPAA plan only if he or she meets HIPAA eligibility requirements and only if the application is declined. If the Applicant qualifies for HIPAA coverage and applied for and qualifies for KPIF coverage, we will enroll him or her in the KPIF plan. For information about HIPAA eligibility, plan benefits, and rates, or to request a copy of a *Membership Agreement*, please call **1-800-634-4579**.

Requirements

Please read the requirements for HIPAA eligibility. All five statements must be true for the Applicant to enroll in a HIPAA plan.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. *Creditable coverage* means continuous health coverage during the qualifying 18-month period immediately preceding this application for enrollment. If there have been multiple coverages during that qualifying period and/or a combination of individual and group coverage, a) there can be a break of no more than 63 days between coverages, and b) the final coverage must have been group coverage. For more information about the types of health coverage that may qualify for creditable coverage, please refer to the *Membership Agreement*, or call us at the information number listed above.
2. My most recent health coverage was through a group health plan, a governmental plan, or a church plan.
3. If I was eligible for continuation of coverage under federal (COBRA) or state (Cal-COBRA) laws, I enrolled in any available continuation coverage and paid all applicable premiums for the entire period for which I was eligible.
4. I do not currently have other health 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.

If all five statements above are true, the Applicant is eligible for HIPAA coverage.

(continues on page 24)

XI HIPAA Eligibility Requirements and Enrollment Information *(continued)*

If the Applicant is eligible and would like to be enrolled in a HIPAA plan in the event that he or she does not qualify for a KPIF plan, please check the box and sign as appropriate. Do not complete this section if the Applicant is not eligible for enrollment in a HIPAA plan.

Print name(s). Use ink only.	All five statements are true. Enroll me in HIPAA if I do not qualify for a KPIF plan.
Applicant/Financially responsible party	☐
Applicant (age 18 or over)	☐

If the Applicant would like to be enrolled in a HIPAA plan, he or she must attach a certificate of creditable coverage or other proof of creditable coverage. Enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, the Applicant will be enrolled for membership in HIPAA.

Use ink only.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 18)

X _____

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