

**Kaiser Permanente for Individuals and Families Membership Application**

**Instructions:** You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan member. Omissions or incomplete answers will delay processing of your application. **Intentional misrepresentation can result in rescission of your Kaiser Permanente for Individuals and Families (KPIF) membership (see Section VI on page 5 for details).** This application becomes part of your permanent record with Kaiser Permanente. If English is not your native or primary language, you may call Member Services toll free at **1-800-632-9700** or **303-338-3800** to request assistance completing this questionnaire. Kaiser Permanente does not discriminate based upon: race; color; national origin; ancestry; religion; sex (including gender, gender identity, or gender-related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth); marital status; sexual orientation; or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from the contract as a subscriber, enrollee, member, or otherwise.

Please print or type in black ink only.

**I. Each person in the family must complete a separate application for membership.**

A. Height (without shoes)  Ft.  In. Weight (dressed)  Lbs.

B.  Male  Female

C.  Single  Married

D. If you were a previous Kaiser Permanente member under a different name, what name did you use:

Last name  First name

Previous medical record number

E. Membership application for:

Last name

Mr.  Mrs.  Miss  Ms. First name  MI

F. Date of birth

To make sure our Kaiser Permanente for Individuals and Families plan is right for you, please take a few moments to consider these questions:

Yes  No Do you work for an employer who has from one to 50 employees who work 24 hours or more a week?

If you answered No, you've picked the right health plan. If you answered Yes, please answer the following questions and read on.

Yes  No Will your employer receive a tax deduction for your health care coverage?

Yes  No Will your employer pay for your coverage or reimburse you for any portion of your premium?

**Important:** If you answered Yes to either of the last two questions, you are not eligible for Kaiser Permanente for Individuals and Families plan coverage. However, you may be eligible for small group health insurance coverage.

1. How many times have you been hospitalized in the last 12 months, except for pregnancy?

- Never  2 times  
 1 time  3 or more times

2. How many times have you required medical attention in the last 12 months, except for pregnancy?

- 0-2 times  6-8 times  
 3-5 times  9 or more times

3. Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?

- Yes  No

4. (a) If you have ever regularly smoked cigarettes, what is or was your average daily usage?

- ½ pack or less  2 or more packs  
 1 pack  N/A  
 1½ packs

(b) For how long?

- 9 years or less  20-29 years  
 10-14 years  Over 30 years  
 15-19 years  N/A

5. In the last 5 years, have you taken or used illegal drugs or prescription drugs not prescribed by a doctor?

- Yes  No

6. In the last 5 years, have you participated in a program that deals with YOUR alcohol or substance abuse?

- Yes  No

(Health questionnaire continues on page 2.)

**I. Each person in the family must complete a separate application for membership. (continued)**

7. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (please check *all* that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> AIDS, ARC                                    | <input type="checkbox"/> Painful menstrual cycle or female reproductive disorder |
| <input type="checkbox"/> Sexually transmitted diseases                | <input type="checkbox"/> Lupus/SLE   |
| <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> Silicone breast implants                                |
| <input type="checkbox"/> Hernia not repaired/GI reflux                | <input type="checkbox"/> Melanoma/Breast/Prostate/Bladder cancer                 |
| <input type="checkbox"/> Back/Neck pain or injury                     | <input type="checkbox"/> Skin cancer   |
| <input type="checkbox"/> Bone marrow transplant                       | <input type="checkbox"/> Other cancers   |
| <input type="checkbox"/> Crohn's or ulcerative colitis                | <input type="checkbox"/> Aneurysm  |
| <input type="checkbox"/> Depression or anxiety                        | <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's                          |
| <input type="checkbox"/> Mental health condition                      | <input type="checkbox"/> Neurologic condition                                    |
| <input type="checkbox"/> Eating disorder, anorexia nervosa/bulimia    | <input type="checkbox"/> Pacemaker   |
| <input type="checkbox"/> Heart or valve condition                     | <input type="checkbox"/> Prostate condition                                      |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Rheumatoid arthritis                                    |
| <input type="checkbox"/> Emphysema/COPD                               | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Lung condition, other chronic condition      | <input type="checkbox"/> Sickle cell anemia                                      |
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> High cholesterol                             | <input type="checkbox"/> Stomach or intestinal problems                          |
| <input type="checkbox"/> Kidney/Bladder condition incl. kidney stones | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Liver condition                              | <input type="checkbox"/> Lumps   |
| <input type="checkbox"/> Gallstones                                   |  |
| <input type="checkbox"/> Anemia or other blood disorder               |  |
| <input type="checkbox"/> Ulcer  |  |
- Any other health concerns, complaints, or symptoms that you did not provide information for elsewhere on this questionnaire \_\_\_\_\_

None of the above

8. (a) Have you consumed 2 or more alcoholic beverages per day on a regular basis within the last 6 months?

- Yes  No

(b) If Yes, what was the type and quantity consumed daily?

- Beer:  None or less than 32 oz.  32 oz. or more  
 Wine:  None or less than 18 oz.  18 oz. or more  
 Hard:  None or less than 4 oz.  4 oz. or more

9. Within the last 12 months have you had any of the following signs or symptoms for which you have not yet seen a health care professional? Please check any items below that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Rectal bleeding  |
| <input type="checkbox"/> Swollen glands                               | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Chest pain                                   | <input type="checkbox"/> Dizziness        |
| <input type="checkbox"/> Shortness of breath                          | <input type="checkbox"/> Chronic fatigue  |
| <input type="checkbox"/> Abdominal or pelvic pain                     | <input type="checkbox"/> Rash             |
| <input type="checkbox"/> Loss of consciousness                        | <input type="checkbox"/> Skin lesions     |
| <input type="checkbox"/> Unexplained weight loss                      | <input type="checkbox"/> Lumps            |
| <input type="checkbox"/> Chronic pain (if Yes, please explain): _____ |   |

None of the above

10. Are you currently taking birth control medication, estrogen, Premarin, Depo-Provera, etc.?

- Yes  No

11. (a) Are you regularly taking any prescription medications other than those in question 10?

- Yes  No

(b) If Yes, please list each medication here: \_\_\_\_\_

12. Are you pregnant or an expectant father, or will you be providing medical insurance coverage for a newborn or new adoptee within the next 9 months?

- Yes  No

13. For females over age 11 only:

(a) Are you premenstrual (have never menstruated), postmenopausal, or have you had a hysterectomy or tubal ligation?

- Yes  No

(b) If No, date of your most recent normal menstrual period:

/  /   
 Month Day Year

**Please review the health questionnaire to be sure you have answered all questions, 1–13.**

**II. Billing information (head of household only)**

Only the head of household must complete Section II—Billing information, and Section III—Family to be covered.

1. Person to be billed:

Last name

Mr.  Mrs.  
 Miss  Ms.

First name

MI

Date of birth

Social Security number (SSN) or taxpayer ID

Street address

Apt. no.

City

State

ZIP code

2. Account information

- Addition of a family member to an existing account
- Switching coverage from an existing account
- New account

3. For which plan would you like to apply?

- \$2,000 Deductible Plan with HSA Option (100%)
- \$2,000 Deductible Plan with HSA Option (80%)
- \$5,000 Deductible Plan (70%)
- \$2,000 Deductible Plan (70%)
- \$2,000 Deductible Plan (70%) with Rx
- \$30 Copayment Plan

4. Kaiser Permanente medical record number

5. Home phone

6. Work phone

7. Primary language:

- English
- Other \_\_\_\_\_

**For applicants using an insurance broker:**

8. Broker name

9. Broker ID

I understand that the broker of record may receive monetary and/or nonmonetary payments from the Health Plan and/or Kaiser Permanente Insurance Company (KPIC) in connection with the purchase of this health plan coverage.

**III. Family to be covered (other than head of household)** Each person in the family must complete a separate application for membership.

Relationship	Name – Last	First	MI	Date of birth	Sex (M/F)	SSN
Spouse	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____

The head of household (or subscriber) and spouse, if applying together, must complete, sign, and date this page for their applications to be considered complete.

**IV. Business Group of One Determination Form**

Please complete and sign this form to determine if you are a self-employed Business Group of One.

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you or your spouse either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you or your spouse have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that is sufficient to pay for the annual premiums for the Business Group of One's health benefit plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?

Please sign below

I, \_\_\_\_\_, attest that the answers to the questions contained in this form are true and correct.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, attest that the answers to the questions contained in this form are true and correct.

Signature of spouse \_\_\_\_\_ Date \_\_\_\_\_ Applicant's or spouse's business \_\_\_\_\_

If you or your spouse answered Yes to all four questions listed above, please complete and sign the following *Business Group of One Disclosure Form*.

**V. Business Group of One Disclosure Form**

Please read and sign the following disclosure required by Colorado law:

I, \_\_\_\_\_, meet the definition of a self-employed Business Group of One as attested to on the accompanying *Business Group of One Determination Form*. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group Business Group of One policy are limited to plan design, the carrier's overall cost and utilization trends (*index rate*), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a *Colorado Health Plan Description Form* for the plan for which I am applying.

Applicant's name \_\_\_\_\_ Applicant's signature \_\_\_\_\_

Applicant's business \_\_\_\_\_ Date \_\_\_\_\_

**All Applicants: Please read the following information and sign in the space below.**

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative at 1-800-634-4579 before signing this application.

**VI. Conditions of Acceptance**

You must fully answer each question in this application even though you may already be a Health Plan member. If we decide to accept you for KPIF membership, our decision would be based primarily on health information you provided in your application and would be conditioned on your actual health being consistent with the information you provided. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician to clarify your specific condition.

If you are a present or former Health Plan member, we will review your prior health history with Kaiser Permanente prior to making our decision. We reserve the right to review your use of health services during your first year of membership to confirm consistency with your pre-enrollment health information.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or a dependent, take the time to make sure the information is accurate before submitting it to us.

**Note:** If we discover that you intentionally provided incomplete or incorrect material information in the enrollment process, we will rescind your membership. This means that we will completely void membership so that no coverage ever existed. You will have to pay as a nonmember for any services we covered.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf.

**Important note to the Applicant:** You or your authorized representative may request a copy of your completed application. For more information, please call 1-800-634-4579.

<b>X</b>	
Applicant/Head of household	Today's date

<b>X</b>	
Applicant's spouse	Today's date

<b>X</b>	
Applicant/Dependent (age 18 or over)	Today's date

**Important:** Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. Use black ink only.

**VII. Insurance Fraud Warning**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**VIII. Authorization to Obtain or Release Medical Information**

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional who has provided any services to me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product (each, an *Applicant*) to give Kaiser Foundation Health Plan of Colorado, or its affiliates (*Kaiser Permanente*), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, **any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, sexually transmitted diseases, HIV (human immunodeficiency virus) status, AIDS (acquired immune deficiency syndrome), or ARC (AIDS-related complex) (Medical Information)** of the Applicant. However, Medical Information does not include genetic information or *psychotherapy notes* (as defined by 45 C.F.R. § 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize Kaiser Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the coverage.

I will sign new authorizations, if necessary, so that, in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits, Kaiser Permanente may request, use, and disclose any Medical Information, HIV/AIDS- or ARC-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of twenty-four (24) months. 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 is in Kaiser Permanente's *Notice of Privacy Practices*.

<b>X</b>		
	<b>Applicant/Head of household</b>	<b>Today's date</b>
<b>X</b>		
	<b>Applicant's spouse</b>	<b>Today's date</b>
<b>X</b>		
	<b>Applicant/Dependent (age 12 or over)</b>	<b>Today's date</b>

**Important:** Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. In addition, all Applicants age 12 or over must sign and date above on the appropriate signature line. **Use black ink only.**

**IX. Kaiser Foundation Health Plan Arbitration Agreement**

Except for small claims court cases, claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in the Colorado Revised Statutes, Section 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

**Note:** Any intentional misrepresentation of your current health status may void your coverage and the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

<b>X</b>		
	<b>Applicant/Head of household</b>	<b>Today's date</b>
<b>X</b>		
	<b>Applicant's spouse</b>	<b>Today's date</b>
<b>X</b>		
	<b>Applicant/Dependent (age 18 or over)</b>	<b>Today's date</b>

**Important:** Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18. **Use black ink only.**

**X. Information about CoverColorado**

**Colorado residents** who do not qualify for Kaiser Permanente for Individuals and Families plan may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. CoverColorado does not impose pre-existing conditions or limitations on coverage. For information about CoverColorado, please contact that agency directly at:

CoverColorado  
425 S. Cherry Street, Suite 160  
Glendale, CO 80246  
(303) 863-1960

<b>For office use only:</b>	PH 0    CSC 0	AREA NO. _____
MEDICAL RECORD NO. _____	FAMILY ACCOUNT NO. _____	PURCHASER NO. _____
DATE RECEIVED _____	STATUS: 0 APPROVED 0 DENIED	EFFECTIVE DATE _____