

## Individual and Family Plans

# 2017 Kaiser Foundation Health Plan of Washington enrollment application

For coverage effective on or after Jan. 1, 2017

Thank you for considering us for your individual and family coverage.  
To apply for enrollment:

- Complete this application in black or blue ink only.
- Read the application carefully and answer all applicable sections completely. **All pages must be returned and your signature is required.**
- Confirm that you meet all the eligibility requirements called out throughout this application.
- Send the application and supporting documents to:  
Kaiser Permanente Individual and Family Sales  
320 Westlake Ave. N., Suite 100  
Seattle, WA 98109-5233

For application deadlines, see page 6, "Coverage effective date."

- Call us at **1-800-358-8815** or **206-448-4141** if you have any questions about this application or the process.

### FOR INTERNAL USE ONLY

Date application was received:

Effective date: \_\_\_\_\_

## 1. APPLICATION TYPE

**Check the boxes below that apply to you.** Please note: Coverage usually begins on the first of the month (see "Coverage effective date" on page 6 for details). If you are applying outside of open enrollment, you must have a qualifying event.

**I am/we are new applicants.**

**I am/we are current members and wish to:**

Add dependent(s)       Change plans

Change from dependent to subscriber

(Please complete subscriber information in Section 3 on page 3.)

**I am applying for coverage for a child or children only.** (In Section 3 on page 3, please include parent/guardian information under "Applicant/subscriber" and include child information under "Dependent child.")

Kaiser Permanente refers to Kaiser Foundation Health Plan of Washington

## 2. QUALIFYING EVENTS

Complete if you're applying outside of open enrollment and submit your documentation along with your application. You must enroll no more than 60 days from the date of the qualifying event. **Date of event:** \_\_\_\_\_

CHECK ONE	QUALIFYING EVENTS	DOCUMENTATION
<input type="checkbox"/>	Loss of your health coverage, including an employer plan, unless the loss is based on misrepresentation of a material fact affecting coverage or fraud related to the health coverage.  Note: Voluntarily terminating other health coverage or being terminated for not paying premiums will not be considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.	For loss of employer group coverage, a copy of the COBRA offer letter or a letter from your employer listing each applicant that experienced a loss in coverage, the reason for the termination, and when the termination occurred. For loss of individual coverage, a copy of the carrier termination letter or Certificate of Creditable Coverage listing each applicant that experienced a loss in coverage and when the termination occurred.
<input type="checkbox"/>	No longer eligible for Medicaid or a public program providing health benefits.	Copy of the termination letter from Medicaid or other program indicating loss of eligibility and the date of loss.
<input type="checkbox"/>	A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area.	Copy of termination letter from prior health plan—must include covered individuals and date coverage was lost. A copy of a utility bill with prior address dated within last 60 days <b>PLUS</b> One additional document from the following list: <ul style="list-style-type: none"> <li>• Current utility bill with the address listed on application</li> <li>• WA Driver's License (enlarged 125%)</li> <li>• Signed rental agreement</li> <li>• Copy of voter's registration card</li> <li>• Bank statement or check with address listed on application</li> <li>• Current student enrollment or letter from college/university registrar noting residence</li> </ul>
<input type="checkbox"/>	The birth, adoption, or placement for adoption, of the applicant for whom coverage is sought.	Copy of the official birth certificate, adoption papers, medical support order, or the court order appointing a guardian.
<input type="checkbox"/>	The Health Benefit Exchange discontinues your coverage and the three-month grace period (delinquency period) for continuation of coverage has expired.	Letter from the Exchange or health plan indicating coverage was discontinued by the Exchange and the three-month grace period for continuation of coverage has expired.
<input type="checkbox"/>	Your employer doesn't pay your COBRA premiums on time.  Note: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying your COBRA, you must wait for the next Open Enrollment Period.	Copy of the letter from employer or COBRA administrator indicating loss was due to failure of the employer to remit premium.
<input type="checkbox"/>	Your COBRA coverage has been exhausted or you reach the lifetime limit on your COBRA plan.  Note: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying your COBRA, you must wait for the next Open Enrollment Period.	Copy of the letter from employer or COBRA administrator indicating loss of COBRA due to exhausting the benefits or exceeding lifetime limit in the plan and no other COBRA coverage is available.
<input type="checkbox"/>	Loss of coverage on a group plan due to age.	Copy of letter from employer of prior health plan indicating loss of coverage due to age.
<input type="checkbox"/>	Marriage or entering into a domestic partnership (dependents also qualify).	Copy of marriage certificate or domestic partnership registration.
<input type="checkbox"/>	Loss of coverage as the result of dissolution of marriage or termination of a domestic partnership.	Copy of divorce decree, annulment papers, or affidavit of termination of domestic partnership, and copy of termination letter from prior health plan.
<input type="checkbox"/>	Discontinuance of Washington State Health Insurance Pool (WSHIP) coverage.	Copy of the termination letter from WSHIP.
<input type="checkbox"/>	Other circumstances where your health plan is no longer available to a subset of people that includes you.	Copy of the termination letter from the prior health plan indicating loss of coverage due to special circumstances.

3. SUBSCRIBER, DEPENDENT, AND ADDRESS INFORMATION

<b>Applicant/subscriber name</b> Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Spouse/domestic partner name</b> Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

\*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use and the use of e-cigarettes.

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Dependent child name</b> (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* <input type="checkbox"/> Yes <input type="checkbox"/> No		

REQUIRED—Residential street address (no P.O. Box)			
City	State	ZIP	County

Mailing address	City	State	ZIP
Email address**			Contact phone number

\*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use and the use of e-cigarettes.

\*\*By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

4. **BILLING INFORMATION**

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about paying online or setting up recurring electronic payments will be included with your welcome letter once you are enrolled.

**Check one** of the following three billing options and fill in the billing information (if applicable).

**1. Send bill to:** subscriber mailing address.\*

**OR**

**2. Send bill to:** address other than subscriber mailing address.\*

**3. Send bill to:** guarantor at the address below.\*

Billing name	Guarantor name
Address	Address
City	City
State/ZIP	State/ZIP
Billing phone number	Guarantor phone number
Billing email	Guarantor email

\*The applicant, or financial guarantor for children under the age of 18 and/or dependents who are totally incapable of self-sustaining employment, is responsible for premium payments. To the extent permissible by law, a third-party paying premiums on behalf of an applicant is required to either (1) set up an individual online account for payment at [kp.org/wa/pay](http://kp.org/wa/pay) or (2) submit one check per subscriber policy if receiving a paper bill.

5. **PLAN CHOICES**

**Check one** box to indicate your health plan selection.

<p><b>Kaiser Foundation Health Plan of Washington</b> Core provider network</p>
<p>These plans are only available in these counties: Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, and Yakima.</p> <p><input type="checkbox"/> Bronze</p> <p><input type="checkbox"/> Core Bronze HSA (see notes below)</p> <p><input type="checkbox"/> Flex Bronze</p> <p><input type="checkbox"/> Core Silver HSA (see notes below)</p> <p><input type="checkbox"/> VisitsPlus Silver HD</p> <p><input type="checkbox"/> Flex Silver</p> <p><input type="checkbox"/> Flex Gold</p>
<p><b>HSA notes:</b></p> <ul style="list-style-type: none"> <li>• Kaiser Permanente has partnered with HealthEquity to administer a Health Savings Account (HSA) that is integrated with your HSA plan. <b>Do you want to choose HealthEquity for your HSA?</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></li> <li>• Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family.</li> <li>• Subscribers under age 18 can enroll in the health plan but are not eligible for an HSA.</li> </ul>

## 6. DENTAL COVERAGE

Pediatric dental coverage is mandatory for anyone under the age of 19.

You may elect to cover those 19 and older on your plan as well.

I am electing:

- Pediatric coverage: for enrollees up to age 19.
- Family coverage: for all enrollees including spouse/domestic partner and dependent children up to age 26.

Coverage provided by Delta Dental of Washington, 9706 Fourth Ave. N.E., Seattle, WA 98115-2157.

OR

- I do not want to enroll in dental coverage at this time. I certify that I have, or will have, other pediatric dental coverage for anyone under age 19 covered by my medical plan. I understand that a suspension of my medical plan benefits may occur if I do not supply proof of applicable other pediatric dental coverage to Kaiser Permanente within 60 days of my medical plan enrollment.

Submit proof of other dental coverage to Kaiser Permanente by scanning it and securely emailing it to ifsales@kp.org or send it via mail or fax to Kaiser Permanente Individual and Family Sales, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109 or fax **206-877-0655**.

## 7. TERMS AND CONDITIONS

1. **Residency eligibility.** You must reside in one of the following counties when purchasing a medical plan in the **Kaiser Foundation Health Plan of Washington Core Network:** Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima. Kaiser Permanente, at any time, may request proof of residency to ensure you reside within the service area.
2. **Medicare eligibility.** You or your dependent(s) who are applying are not entitled to Medicare; if you are unsure of your Medicare eligibility please visit medicare.gov. If you or your dependent is age 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration. If it is discovered that you or your dependent(s) were entitled to Medicare prior to enrolling in a Kaiser Permanente Individual and Family plan, Kaiser Permanente reserves the right to terminate coverage.
3. **Dependent children.** First 3 children ages 0–20 each will be charged the age 0–20 rate. There's no charge for additional children ages 0–20. Each child older than age 20 will be charged the rate applicable to his or her individual age.
4. **Adults applying as a guarantor (dependent-only coverage).** A guarantor may enroll only dependent children who are under the age of 18 and dependents who are totally incapable of self-sustaining employment. Financial guarantors are required for children under the age of 18. A guarantor will be enrolled as a subscriber without medical benefits. As a guarantor, you hereby agree to accept the financial and contractual responsibilities for the dependent listed on the application.
5. **Coverage effective date.** The effective date of your application is based upon Kaiser Permanente's receipt of your completed application. All application documents must be received in the Individual and Family Sales Department at Kaiser Permanente.
  - If you are requesting to enroll during the open enrollment period, and wish to enroll for a Jan. 1 effective date, your application must be received by Dec. 31, 2016.
  - If you are requesting to enroll outside of the open enrollment period due to a qualifying event:
    - For application documents received on or before the last day of the month, coverage will begin on the first day of the following month.
    - For coverage due to a birth, effective as of date of birth.
    - For those adopted or placed for adoption, coverage is effective the date of adoption or placement, whichever occurs first.
    - For special enrollment based on marriage or domestic partnership, or loss of minimum essential coverage, coverage will be effective on the first date of the next month.

6. **Premium payments.** Premium payments are due on a calendar-month basis on or before the first day of each month, subject to a grace period of 10 days. Payment can be made online at [kp.org/wa/pay](http://kp.org/wa/pay), pay by mail with payment coupon, pay by phone by calling 1-888-901-4636, or you can pay using your bank’s online bill pay service.
7. **Revoking coverage.** Intentionally providing false or misleading information on your application documents or failing to pay monthly premiums may result in Kaiser Permanente’s refusal to extend coverage, cancellation of coverage, or rescission of coverage for you or your family members.
8. **Applicant’s financial liability.** a) Pre-enrollment services: If any hospital or medical service is rendered to you or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These non-covered services will be billed to you at the full cost. Regardless of whether you or your dependents become a member, you will be responsible for payment of such charges; b) Prior authorizations: Upon termination from any Kaiser Permanente Individual and Family plan, all prior authorizations for health care coverage for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services you receive.
9. **Dental coverage.** When the family dental coverage is purchased, all individuals on the medical plan will be enrolled with dental. When medical coverage is terminated, dental coverage will also be terminated.

8. **PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)**

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Kaiser Permanente sales representative or producer name

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Kaiser Permanente producer ID number

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Company/house name (if applicable)

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Kaiser Permanente house ID number

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Phone number

9. **ACKNOWLEDGEMENTS AND SIGNATURES**

**I acknowledge that:**

- I have read and agree to the Terms and Conditions (Section 7) included with this application.
- This application becomes part of my Medical Coverage Agreement.
- I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt.
- My age-band rate is based on my age when my coverage becomes effective or my age as of Jan. 1 when the plan renews; premium amount is subject to change upon 30 days’ written notice, which will be sent to the subscriber’s mailing address.
- If my/our physical residential address changes to a different county in the Kaiser Permanente service area, my premium rates may be subject to change.
- The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 8) to release to Kaiser Permanente information about any person listed on my Individual and Family plan application documents.

- Under the Health Insurance Portability and Accountability Act (HIPAA), Kaiser Permanente, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Kaiser Permanente may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Kaiser Permanente Medical Coverage Agreement.
- I authorize Kaiser Permanente to disclose information about the selection of a plan to the Producer of Record (Section 8) for the duration of coverage and final reconciliation of the Kaiser Permanente account. A signed Authorization to Disclose Health Plan Information form is required for all other disclosures to the Producer of Record.

I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

- Documentation:** I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.
- Signature:** This application has been signed by me and my spouse/domestic partner, if applicable.
- If not the primary applicant, I am the:**
  - Parent     Holder of Power of Attorney (attach legal documentation)
  - Legal Guardian (attach legal documentation)

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Primary applicant/(parent/legal guardian) signature Date

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Spouse/domestic partner signature Date