To: Kaiser Permanente Direct Pay Department

Fax: 303-942-4315

From: Solera Insurance

Re:

Notes:

KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES MEMBERSHIP APPLICATION

NOTE: This application may become part of your permanent medical record if your membership is approved. It may be reviewed again with you by a physician. You must answer all questions completely. Omissions will delay processing of your application.

I. EACH PERSON IN THE FAMILY MUST COMPLETE A SEPARATE APPLICATION FOR MEMBERSHIP

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

B. O Male O Female

C. O Single O 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 ____

O Mr. O Mrs. O Miss O Ms. First Name ____ M.I. ____

F. Date of Birth ____

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

O Yes O 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.

O Yes O No **Will your employer receive a tax deduction for your healthcare coverage?**

O Yes O 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 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?

O Never O 2 times
O 1 time O 3 or more

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

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

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?

O Yes O No

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

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

(b) For how long?

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

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

O Yes O No

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

O Yes O No

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):

O AIDS, ARC
O Sexually transmitted diseases
O Hepatitis
O Hernia not repaired/GI reflux
O Back/Neck pain or injury
O Bone marrow transplant
O Crohn's or ulcerative colitis
O Depression or anxiety
O Mental health condition
O Eating disorder, anorexia nervosa/bulimia
O Heart or valve condition
O Asthma
O Emphysema/COPD
O Lung condition, other chronic condition
O High blood pressure
O High cholesterol
O Kidney/Bladder condition incl. kidney stones
O Liver condition
O Gallstones
O Anemia or other blood disorder
O Painful menstrual cycle or female reproductive disorder
O Lupus/SLE
O Silicone breast implants
O Melanoma/Breast/Prostate/Bladder cancer
O Skin cancer
O Other cancers
O Aneurysm
O MS/ALS/Parkinson's/Alzheimer's
O Neurologic condition
O Pacemaker
O Prostate condition
O Rheumatoid arthritis
O Seizures
O Sickle cell anemia
O Diabetes
O Stomach or intestinal problems
O Stroke
O Lumps
O Ulcer
O Other conditions not specifically listed on application ____
O 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?

O Yes O No

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

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

9. Do you have unexplained and/or undiagnosed symptoms such as (please check all that apply):

O Fever
O Swollen glands
O Chest pain
O Shortness of breath
O Abdominal or pelvic pain
O Loss of consciousness
O Unexplained weight loss
O Other
O None of the above
O Rectal bleeding
O Loss of appetite
O Dizziness
O Chronic fatigue
O Rash
O Skin lesions
O Lumps

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

O Yes O No

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

O Yes O No

(b) If Yes, please list each medication below: ____

12. Are you an expectant parent?

O Yes O No

13. For females over age 11 only:

(a) Are you pre-menstrual (have never menstruated), post-menopausal or have you had a hysterectomy or tubal ligation?

O Yes O No

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

____ / ____ / ____
month day year

Kaiser Foundation Health Plan of Colorado, Box 378022, Denver, CO 80237-9933

OVER⟶

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

0 Mr. 0 Mrs.
0 Miss 0 Ms.

First Name

M.I.

Date of Birth

Social Security Number or Taxpayer I.D.

Street Address

Apt. No.

City

State

ZIP Code

2. Account Information
 0 Addition of a family member to an existing account
 0 New account
 0 Change from one plan design to another

3. For which plan would you like to apply?
 0 $2,000 Deductible Plan with HSA Option (100%)
 0 $2,000 Deductible Plan with HSA Option (80%)
 0 $5,000 Deductible Plan (70%)
 0 $2,000 Deductible Plan (70%)
 0 $30 Copayment Plan

4. Kaiser Permanente Medical Record Number:

5. Home Phone:

6. Work Phone:

For applicants using an insurance broker

7. Broker/General Agent Name:

8. Broker/General Agent Number:

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	M.I.	Date of Birth	Sex (M/F)	S.S.N.
Spouse						
Child						
Child						
Child						
Child						
Child						
Child						
Child						

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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	
❑Yes ❑No	❑Yes ❑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?
❑Yes ❑No	❑Yes ❑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?
❑Yes ❑No	❑Yes ❑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.
❑Yes ❑No	❑Yes ❑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 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 services representative at 1-800-634-4579 before signing this application.

VI. HEALTH STATUS UPDATE

You must immediately inform us if your health status or current medication changes at any time before your membership in Kaiser Permanente for Individuals and Families Plan becomes effective. Changes in health status may result in revocation of the approval for enrollment. Failure to inform us of such change can void your Health Plan membership. You can choose to update your application information by telephone **1-800-634-4579**, by fax 1-800-369-8010, or by writing to us at **Kaiser Foundation Health Plan, Individual Programs, 393 E. Walnut Street, LsRs-5, Pasadena, CA 91188-8539, Attention: Health Status Update**. All written and fax correspondence must be signed and dated by the subscriber.

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**.

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 REVIEW EXISTING INFORMATION

I hereby authorize Kaiser Foundation Health Plan to review any existing Kaiser Permanente medical records and history of care provided to me or my dependents as members of Kaiser Foundation Health Plan for a period of up to 5 years preceding this application for membership in the Kaiser Permanente for Individuals and Families Plan. This authorization applies to all types of care including the diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, or AIDS-related condition, and is limited to information reasonably related to determining my/our eligibility for membership in the Kaiser Permanente for Individuals and Families Plan. I understand that Kaiser Foundation Health Plan will not redisclose any information received through this review except with my written consent or as permitted by federal and/or state laws and regulations. This authorization for review is effective during all times that my/our application and/or eligibility status are being considered. If accepted as a Kaiser Permanente for Individuals and Families Plan member, I further authorize Kaiser Foundation Health Plan, without limitation and including all categories of care stated above, to review my Kaiser Permanente medical records, including pharmacy records, for a period of up to 12 months following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application.

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.)

To apply for membership, YOU MUST SIGN HERE

X Date

Applicant's Signature if 18 or older or emancipated minor *(otherwise, Parent/Legal Guardian signature required) USE BLACK INK ONLY.*

Please continue on page 5.

For Office Use Only:	PH 0 CSC 0	AREA NO. ______________
MEDICAL RECORD NO.____________________	FAMILY ACCOUNT NO. ______________________	PURCHASER NO. __________
DATE RECEIVED _________________________}	STATUS: 0 APPROVED 0 DENIED	EFFECTIVE DATE __________

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 them directly at:

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