

This is not a group contract.

APPLICANT

| | |
|---|--|
| Plan Number 1502-_____ Contract Type: <input type="checkbox"/> Single <input type="checkbox"/> Family Effective Date of Coverage ___/___/___ (For Health Plan use only) | |
| Name (Last, First, Middle Initial) | Social Security # or TPN |
| Home Address | Date of Birth / / Sex (Circle) M F |
| City | County |
| Home Phone | Business/Day Phone |
| Kaiser Permanente Medical Record Number (if any) | Present Marital Status <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced |
| Primary Care Physician Name | Apt. # |
| | State ZIP Code |
| | Code |

DEPENDENTS TO BE COVERED

| Spouse (Last, First) | Social Security # | Date of Birth | Sex M/F | Date of Marriage | Kaiser Permanente Medical Record # | Primary Care Physician | |
|---------------------------|-------------------|---------------|---------|----------------------------|------------------------------------|------------------------|------|
| | | | | | | Name | Code |
| Dependents (Oldest first) | | | | Relationship to Subscriber | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Do any of the above dependents live at another address? Yes No If Yes, please complete:

Name _____ Address _____

Name _____ Address _____

HIPAA ELIGIBILITY

Please read the following HIPAA requirements and determine whether all statements are true.

- I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. (Refer to the enclosed HIPAA Disclosure Information for "significant break in coverage rules" to determine if you have 18 months.) Yes No
- My most recent health care coverage was through a group health plan, a governmental plan or a church plan. Yes No
- If offered, I have both elected and exhausted all continuation health care coverage available under Federal (COBRA) and state continuation coverage laws. Yes No Not Offered
- I do not currently have other health care coverage and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare. Yes No
- My most recent coverage was NOT terminated for fraud or failure to pay premiums. Yes No
- I have read the above five statements and attest that each of them is completely true. If I answered "No," to any one question, I understand that I do not qualify for HIPAA. Do you qualify for HIPAA coverage? Yes No
- Please attach certificate(s) of creditable coverage or other proof of creditable coverage. Your enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you will be enrolled for membership. I have attached proof(s) of creditable coverage. Yes No

OPEN ENROLLMENT ELIGIBILITY

Please read the following Open Enrollment requirements and determine whether all statements are true.

- I am not applying for coverage as an employee of an employer, member of an association, or member of any other group. Yes No
- I do not have any other health coverage and am not eligible to be covered under any private or public health benefit plan including: Medicare or Medicare supplement policy, Medicaid, any COBRA or state continuation coverage plan, or other health benefits arrangement. Yes No
- I am not currently confined to a health care facility due to chronic illness or permanent injury. Yes No

SIGNATURE

The information provided in this application is true and correct to the best of my knowledge, and I accept the conditions and terms in the acknowledgement section on page three of this application which I have read and understand. I understand that my dependents, as Health Plan Member(s), will be subject to the terms and conditions of the Agreement. I agree to guarantee all payments due under his/her benefit plan. I understand that if I provide written notification to the Health Plan within 72 hours of signing the Application my coverage will be cancelled as of the postmark date of the cancellation notice.

In the event that the applicant is a minor or is incompetent, the applicant's name should be entered on the applicant's signature line, and the parent or guardian should enter his/her name and signature below.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

ELIGIBILITY GUIDELINES

In order to be eligible for coverage under the Plan, you must (1) permanently reside in our service area, (2) be a "federally eligible individual", as defined by HIPAA, for enrollment in a HIPAA plan or be a "non-federally eligible individual" for enrollment in an Open Enrollment plan and (3) meet eligibility requirements established by us.

You are responsible for providing updated information including, but not limited to, life events and changes in dependent status.

Health Plan reserves the right to revoke acceptance of this application or terminate coverage for you and your dependents, retroactive to the effective date, upon any or all of the following conditions: (1) submission of any incorrect or incomplete answers on this Application or in communications regarding it, or (2) failure to provide updated information. If your coverage is terminated retroactively, you will be billed at nonmember rates for all services you received through Health Plan.

An eligible Family Dependent is defined as any of the following individuals:

1. Your Spouse.
2. Your or your Spouse's children (including adopted children or children placed with you for adoption) who are under age 28.
3. Other dependent persons (but not including foster children) who meet all of the following requirements:
 - They are under age 28 and;
 - You or your Spouse is the court-appointed guardian (or was before the person reached age 18).

PAYMENT

If you are accepted into the HIPAA or Open Enrollment Plan, your credit card will be charged for the first month's premium.

A monthly billing statement will be mailed to your home after initial enrollment. This is a prepaid contract. Payment is due on or before the first day of each month. If payment is not received by this date, your account will be subject to termination.

Payment made by: Credit Card Check (Make checks payable to Kaiser Permanente)

MasterCard VISA DISCOVER American Express

Credit Card Number _____ Expiration Date _____

Name as it appears on the card _____ Amount _____

Signature of Cardholder _____ Date _____

ACKNOWLEDGEMENTS

I hereby apply for Kaiser Permanente membership for myself and eligible family dependents as listed on this form.
I understand that my coverage and benefits may be affected by my failure to provide complete and accurate information.

I hereby certify that the information submitted on this form is complete and true, and correct to the best of my knowledge, and meets the eligibility guidelines.

I understand that if this request is accepted by Kaiser Foundation Health Plan of Ohio (Health Plan), the benefits for which we will be eligible will be in accordance with the Agreement applicable to the type of plan for which we are enrolled. This Agreement is titled *HIPAA Standard Plan Evidence of Coverage, HIPAA Basic Plan Evidence of Coverage, Open Enrollment Standard Plan Evidence of Coverage, or Open Enrollment Basic Plan Evidence of Coverage*, depending on the plan we have chosen and contains the appropriate benefit schedule. I understand this Agreement can be obtained from Health Plan.

I hereby authorize any physician, hospital or other health care provider and any insurer to furnish Health Plan and The Ohio Permanente Medical Group (OPMG) with any information regarding the health and treatment of each person covered by this application.

I authorize Health Plan and OPMG to exchange medical information regarding any person included under my coverage and to provide such information to other health care providers and to insurers, as necessary, for the provision of care, the administration of the Agreement, and the settlement of claims from the date this authorization is signed.

I understand and agree that whenever necessary in the administration of benefits under the Agreement or any other health care coverage, to investigate and settle claims, or to conduct quality assurance, peer review or utilization review, Kaiser Permanente may discuss with Health Plan medical information related to this Application.

I also consent to the assignment of benefits to Health Plan which I may have in circumstances where a party other than Health Plan may be responsible for all, or a portion of, the services provided to me.

This authorization is effective immediately 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 Kaiser Foundation Health 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 and other 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*.

I have read and understand all of the above conditions and terms.

Any person who intentionally defrauds or knowingly facilitates a fraud or misrepresentation against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SIGNATURE

Plan Option Selection

You may choose between HIPAA Basic, HIPAA Standard, Open Enrollment Basic, or Open Enrollment Standard. Please refer to the schedule of Benefits and Services chart for a description of covered benefits and services, including copayments and the rate chart for monthly dues, under each option.

Please place a check mark next to the plan option in which you want to be enrolled.

HIPAA Basic HIPAA Standard Open Enrollment Basic Open Enrollment Standard

Subscriber/Applicant Signature _____ Date _____