KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St., Rockville, MD 20852

Application for health coverage

Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente).

- If you want coverage for your family on the same Kaiser Permanente plan, please fill out 1 application for the family.
- If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for Kaiser Permanente coverage, you must live in our Maryland service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, do not complete this application. You must apply for coverage through Maryland Health Connection at **marylandhealthconnection.gov**.

Apply faster online

- You can apply faster online at **buykp.org/apply**.
- If you'd like to email us, please apply online and set up a secure email account.

Things to remember

- Please answer all questions and type or print using ink only.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you are applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period guide and include any required documentation so your application will be complete. Your start date may be different than the dates listed above if you apply because of a special enrollment period.
- If you have a current Kaiser Permanente plan that was purchased directly from Kaiser Permanente and would like to change plans, please call **1-800-494-5314** instead of filling out this application.
- To avoid being billed twice, if you are enrolled in a plan through Maryland Health Connection, you must cancel your current plan through **marylandhealthconnection.gov** on or before the start date of your new plan.
- **Make sure your application is complete, signed, and includes your 1st month's premium payment. If your application is incomplete or does not include your 1st month's payment, it may be canceled.**
- Send your complete, signed application and 1st month's premium payment by mail to:

  Membership Administration Dept./KPIF 5W
  Kaiser Permanente Individuals and Families Plans
  Suite 100
  2101 East Jefferson St.
  Rockville, MD 20852-9995

  Or send it by secure fax to:
  Individuals and Families Plans: **301-388-1615**

  Note: Checks must be mailed and cannot be faxed.

Need help?

- For help completing this application, please call **1-800-494-5314**. For TTY for the deaf, hard of hearing, or speech impaired, call **711**.
- **We will provide language assistance at no cost to you.**
- If you are working with an agent or a broker, please call him or her for assistance.

KAISER PERMANENTE®

Primary applicant _____

Step 1: Tell Us When You're Applying

Select 1 option: ○ Open enrollment (11/01/15–01/31/16) ○ A special enrollment period
If you are applying during a special enrollment period, please write the date of your triggering event: _____/_____/_____

Please complete this section if you are applying during a special enrollment period outside of the open enrollment period of November 1, 2015, through January 31, 2016. For enrollment during a special enrollment period, applicants and their dependents may enroll or change health plans following a triggering event, as defined below. This form and payment of your 1st month's premium must be received by Kaiser Permanente within 60 days of the triggering event, unless stated otherwise below.

If you selected "A special enrollment period," choose the triggering event:

○ Loss of health care coverage*

- Loss of minimum essential coverage – NOTE: This does not apply when termination or loss or coverage is due to (a) failure to pay premiums on a timely basis, including COBRA coverage premiums prior to expiration of COBRA coverage, (b) situations allowing for a rescission as specified by law, which involve an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage, or (c) voluntary termination of coverage.

Examples of possible valid reasons for loss of minimum essential coverage (this list is not exhaustive):

- Loss of individual coverage
- Loss of Medicare, certain Medicaid and Children's Health Insurance Program coverage
- Loss of coverage due to losing your job or a reduction in hours

The date of the loss of coverage is the last day you and/or your dependent would have coverage under the previous health plan or coverage;

- Loss of pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and(a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day you and/or your dependent would have pregnancy-related coverage;
- Loss of medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. NOTE: This triggering event allows you and/or your dependent a special enrollment period only once per calendar year. The date of the loss of coverage is the last day that you and/or your dependent would have medically needy coverage; or
- Enrolled in any non-calendar year group health plan or individual health plan coverage and such non-calendar year plan or policy year is ending (even if you and/or your dependent have the option to renew such coverage). The date of the loss of coverage is the date of the expiration of the non-calendar year plan.

○ Gaining or becoming a dependent through marriage, domestic partnership, birth, adoption, placement for adoption, placement for foster care, or through a child support or other court order

○ Determination by Maryland Health Connection that your and/or your dependent's enrollment or nonenrollment in a qualified health plan is (a) unintentional, inadvertent, or erroneous; and (b) the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of Maryland Health Connection, HHS, or a non-Maryland Health Connection entity providing enrollment assistance or conducting enrollment activities

○ Determination by Maryland Health Connection that the qualified health plan (QHP) in which you and/or your dependent are enrolled substantially violated a material provision of contract in relation to you and/or your dependent

○ Determined newly eligible, or newly ineligible, for advance payments of federal premium tax credits, or other change in eligibility for federal cost-sharing reductions

○ A permanent move that results in you and/or your dependent gaining access to new qualified health plans

○ Determined newly eligible for advance payments of the premium tax credit based in part on a finding that you and/or your dependent are enrolled in an employer-sponsored health benefit plan that is not qualifying coverage (you and/or your dependent must be allowed to terminate existing coverage)*

Please call **1-800-494-5314** to determine the start date of coverage for your enrollment.

*You and your dependent have 60 days before and after the loss of coverage to enroll in or change health plans.

If you will be getting federal financial assistance, do not use this form. We can help you apply through **marylandhealthconnection.gov**.

Step 2: Choose Your Health Plan

Choose 1 Kaiser Permanente health plan. If any family members are applying for different health plans, please submit a separate application form for each plan.

Bronze	Silver	Gold	Platinum
○ KP MD Bronze 4500/50/Dental/PedDental	○ KP MD Silver 1500/30/Dental/PedDental	○ KP MD Gold 0/20/Dental/PedDental	○ KP MD Platinum 0/20/Dental/PedDental
○ KP MD Bronze 5000/50/HSA/Dental/PedDental	○ KP MD Silver 2500/30/Dental/PedDental	○ KP MD Gold 1000/20/Dental/PedDental	
○ KP MD Bronze 6000/20%/HSA/Dental/PedDental	○ KP MD Silver 2750/20%/HSA/Dental/PedDental		

Catastrophic Plan

A Catastrophic plan is a high-deductible option for those under age 30 by the effective date and for certain people age 30 and older who have received an exemption due to lack of affordable coverage or hardship. To see if you qualify, please go to **marylandhealthconnection.gov**.

○ KP MD Catastrophic 6850/0/Dental/PedDental

For information about the benefits and limitations, cost-sharing amounts, premiums, and dental plans,* please review the details in your enrollment materials. To request a copy of the *Membership Agreement and Evidence of Coverage* for a particular plan, please call **1-800-494-5314** or contact your agent or broker.

Enhanced Dental HMO Rider

Dental coverage is included in your health plan for all members under age 19. We also offer an optional enhanced Dental HMO Rider dental plan for members age 19 and older for an additional monthly charge. You will not be enrolled in the optional enhanced Dental HMO Rider unless you select the Yes option below.

○ Yes. I would like to enhance my dental coverage by selecting a Dental HMO rider for each member age 19 and older who is applying for coverage.

*Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente), and administered by Dominion Dental Services USA, Inc. (Dominion).

If you will be getting federal financial assistance, do not use this form. We can help you apply through **marylandhealthconnection.gov**.

Step 3: Enter Your Information

PRIMARY APPLICANT

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under age 18, the child is the primary applicant.

Check 1 of the following to indicate the level of coverage you are seeking: ○ Adult(s) ○ Adult(s) and child(ren) ○ Child(ren) only

First name	Middle name	Last name
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Home address (no P.O. boxes, please)		Apt. number
City	State / ZIP	County
Mailing address (if different from home address)		Apt. number
City	State / ZIP	County
Main phone ( ) –	Other phone ( ) –	Preferred language spoken (if not English) / Preferred language read (if not English)

SPOUSE/DOMESTIC PARTNER TO BE COVERED

A domestic partner is a person legally recognized as your domestic partner by Maryland or another state or jurisdiction.

First name	Middle name	Last name
Gender ○ M ○ F / Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

DEPENDENTS TO BE COVERED

If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Medical record number (if any)
First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Medical record number (if any)

Step 4: Parent or Legal Guardian (if the primary applicant is a child under age 18)

First name	Middle name	Last name	Gender ◯ M ◯ F	Date of birth (mm/dd/yyyy)
Same address as primary applicant? ◯ Yes ◯ No If no, fill in your address below.				
Billing address				Apt. number
City	State	ZIP	County	
Main phone ( ) –	Other phone ( ) –			
Preferred language spoken (if not English)	Preferred language read (if not English)			

Step 5: Choose an Authorized Representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application. This person is called an *authorized representative*.

First name	Middle name	Last name	
Street address			Apt. number
City	State	ZIP	County
Phone ( ) –			
By signing, you have appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.			
Primary applicant or parent or legal guardian if the applicant is a child under age 18 X			Date (mm/dd/yyyy)

Step 6: Sign the Application Agreement

Important: All applicants and dependents age 18 or older must read, sign, and date below. If the primary applicant is a child under age 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. If signatures are missing, we cannot continue processing the application.

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- I know that under federal and state law, discrimination isn't permitted on the basis of race, color, national origin, disability, age, sex (gender), or religion. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, cancellation of coverage, and/or denial of insurance benefits.

I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.

I hereby enroll in a Kaiser Permanente for Individuals and Families Plan, underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan). I certify that the representations made herein are true and accurate to the best of my knowledge and belief. I understand that the subscriber or, for a child-only request, the parent/legal guardian, will be financially responsible under this agreement.

The answers provided in this application are representations and not warranties. I hereby certify that I have read and understand all of the above terms and conditions and that the answers I have provided in this application are true and complete to the best of my knowledge and belief.

This document shall be part of any contract and be the basis for any contract issued.

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 301-468-6000 or 1-800-777-7902 before signing this application.

WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Primary applicant (parent or legal guardian for children under age 18) X	Date (mm/dd/yyyy)
Spouse/Domestic partner X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)

The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **301-468-6000** or **1-800-777-7902**.

Step 7: Enter Details for 1st Month's Premium Payment

The billing questions are processed securely and separately from the rest of your application.

Your application must be accompanied by payment for your 1st month's premium. If your payment or payment information is missing or incomplete, your application may be canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Do not send cash through the mail.

BILLING INFORMATION

Complete the following information for the person responsible for making the payment. This is the primary applicant unless someone else is identified in Step 5 as the person responsible for making the payment.

First name	Middle name	Last name	

Billing address	Apt. number

City	State	ZIP	County

Amount of your 1st month's premium
$

PAYMENT OPTIONS

Check your preferred payment option below and complete that section.

◯ CREDIT/DEBIT CARD

If you are paying by credit or debit card, please complete the following information:

Credit/debit card information: ◯ Credit ◯ Debit ◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Cardholder's name as it appears on card

Credit/debit card number	Expiration date (mm/yyyy)

Cardholder's signature	Date (mm/dd/yyyy)
X	

◯ ELECTRONIC PAYMENT

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ◯ Checking account ◯ Savings account

Bank name

Routing number	Account number

(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)

Account holder's full name (print)	Account holder's signature
	X

◯ CHECK ◯ MONEY ORDER

If you are paying by check or money order:

- Make the check or money order out to Kaiser Permanente Individuals and Families Plans.
- Write the name of the primary applicant on the check.
- Mail with this application to the address listed on page 1.

Automatic Monthly Payments

For your convenience, if you paid your 1st month's premium by debit card, credit card, or electronic payment, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

BILLING INFORMATION

Same as 1st month's premium? ◯ Yes ◯ No If no, complete the following information for the person responsible for making the payment.

First name	Middle name	Last name	
Billing address			Apt. number
City		State	ZIP

PAYMENT OPTIONS

I hereby authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), to initiate debit entries for the monthly premium amount from my checking, savings, or credit card account as indicated on this form. This authorization is to remain in effect until Health Plan has received written notification from me of its termination and in such manner as to enable Health Plan reasonable opportunity to act. If an entry made by Health Plan to my account results in an overcharge, I have the right to have that charge credited to my account by Health Plan. Within 30 calendar days following the date the financial institution sent or made available to me a statement of account or notification pertaining to the erroneous entry, I must mail or fax to Health Plan a written notice identifying the entry, stating that the entry was in error, and requesting that Health Plan credit my account or issue a refund for the amount charged in error.

Please continue to make payments by invoice until you receive written notice from Health Plan of the date when the 1st automated deduction will be effective.

◯ CHARGE MY CREDIT/DEBIT CARD

By filling out this section, you are requesting that your premiums be automatically charged to your credit/debit card on your due date and agreeing to the terms outlined above.

Credit/debit card information: ◯ Credit ◯ Debit	◯ Visa ◯ MasterCard ◯ Discover ◯ American Express
Cardholder's name as it appears on card	
Credit/debit card number	Expiration date (mm/yyyy)
Cardholder's signature X	Date (mm/dd/yyyy)

◯ DEDUCT FROM MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on your due date and agreeing to the terms outlined above.

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ◯ Checking account ◯ Savings account	Bank name
Routing number	Account number
(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)	
Account holder's full name (print)	Account holder's signature X

◯ I AM NOT INTERESTED IN THE AUTOMATIC PAYMENT OPTION

For Applicants Using an Agent, Broker, or KPIF Representative

If you used an agent, broker, or Kaiser Permanente for Individuals and Families (KPIF) representative, please make sure he or she completes this page. A KPIF representative includes any KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Primary applicant's first name	Middle name	Last name

I (the applicant) authorize the insurance agent/broker/KPIF representative listed below to share enrollment and disenrollment information specific to this application with Kaiser Permanente. I understand that the agent/broker/KPIF representative listed on this application may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in connection with the purchase of this health plan coverage.

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

Primary applicant or parent or legal guardian for applicants under age 18	Date (mm/dd/yyyy)
X	

AGENT/BROKER INFORMATION

Agent's/broker's first name	Middle name	Last name

Kaiser Permanente–appointed broker identification number	Broker license number/License state

Broker firm name	Broker firm federal tax ID number

Street address	Suite

City	State	ZIP	County

Phone	Fax	Email address
( ) –	( ) –	

General agency name	General agency's federal tax ID number

KPIF REPRESENTATIVE INFORMATION

KPIF representative's first name	Middle name	Last name	KPIF representative's license number