





Application for health coverage

Individual and Family Plans

 Who can use this application?	<p>Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is further referred to as "Health Plan," "we," "us," "our," and "Kaiser Permanente" throughout this form.</p> <p>You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.</p> <ul style="list-style-type: none">• If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If someone in your family wants a different health plan, they must complete a separate application.• To be eligible for KPIF coverage, you must live in our Virginia service area.
 Who should not use this application?	<ul style="list-style-type: none">• If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Please visit kp.org/medicare to learn more about your Medicare plan options or to apply for Medicare coverage.• If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through health benefit exchange at HealthCare.gov.• If you're already a KPIF member, don't use this form. To make changes to your account, call 1-866-410-7536.
 Things to remember	<ul style="list-style-type: none">• If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15.• If you're applying during a special enrollment period, go to kp.org/specialenrollment or call 1-800-494-5314 for instructions.• Please send this application back as quickly as you can – or you can apply faster online at buykp.org/apply.• Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.• Remember, if you're enrolling in a new plan, that won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts.• To make sure your application is processed in time and isn't canceled, please return every page of the application, completed, with all the required signatures, first month's payment, and proof of your qualifying life event (if required). Send these materials by mail to: Employer Services Dept./KPIF 5W Kaiser Permanente for Individuals and Families 2101 East Jefferson St. Rockville, MD 20852-9995 Or send it by secure fax to: 1-855-414-2796 Note: Checks must be mailed and can't be faxed.
 Need help?	<ul style="list-style-type: none">• For help with completing this application, please call 1-800-670-5420 (TTY 711).• We'll provide language assistance at no cost to you.• If you're working with a broker, please call them for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.



STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment (**skip to Step 2**) ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required.** Visit kp.org/specialenrollment or call **1-800-494-5314** for more about qualifying life events.

- | | |
|---|---|
| <input type="checkbox"/> Loss of minimum essential health coverage (write the last full day you had coverage)*
<input type="checkbox"/> Gaining or becoming a dependent through marriage
<input type="checkbox"/> Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
Note: In this case, you also need to choose between 2 effective date options:
<input type="checkbox"/> The date of birth, adoption, or placement for adoption or foster care
<input type="checkbox"/> The first day of the month after gaining the dependent
<input type="checkbox"/> Child support order or other court order to cover a dependent
Note: In this case, you also need to choose between 2 effective date options:
<input type="checkbox"/> The date of the child support order or other court order to cover a dependent
<input type="checkbox"/> The first day of the month after the court order date | <input type="checkbox"/> Permanent relocation with access to new plans
<input type="checkbox"/> Changes in employer health coverage making you eligible for a premium tax credit
<input type="checkbox"/> Determination by the health benefit exchange of exceptional circumstances
<input type="checkbox"/> Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
<input type="checkbox"/> Domestic violence or spousal abandonment occurring within the household |
|---|---|

Please write the date of your qualifying life event. / / (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage. For more about minimum essential coverage, visit kp.org/specialenrollment.

STEP 2: Choose your health plan

Choose one health plan. If any family members are applying for different health plans, please submit a separate application for each plan. For more about minimum essential coverage, visit kp.org/specialenrollment.

Bronze	Silver	Gold	Platinum
<input type="checkbox"/> KP VA Bronze 6000/55/Vision <input type="checkbox"/> KP VA Bronze 7500/40%/Vision <input type="checkbox"/> KP VA Bronze 6900/0%/HSA/Vision	<input type="checkbox"/> KP VA Silver 2500/35/Vision <input type="checkbox"/> KP VA Silver 5000/40%/Vision <input type="checkbox"/> KP VA Silver 6500/40%/Vision	<input type="checkbox"/> KP VA Gold 0/20/Vision <input type="checkbox"/> KP VA Gold 1250/20%/Vision <input type="checkbox"/> KP VA Gold 1700/25%/Vision	<input type="checkbox"/> KP VA Platinum 0/15/Vision

Catastrophic plan

To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you're 30 and older. To see if you qualify, please go to marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf and follow the instructions.

- ☐ KP VA Catastrophic 8550/0/Vision

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, 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 go to kp.org/plandocuments, call **1-800-777-7902**, or contact your broker.

STEP 3: Choose your optional adult dental plan

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

- ☐ Yes. I'd like to enroll in the optional adult dental plan.
☐ No. I'm not interested in the optional adult dental coverage.

STEP 4: 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 18, the child is the primary applicant.

First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any)

State (if any)

Gender:

☐

Male

☐

Female

Phone

Home address (no P.O. boxes, please)

City

State

ZIP code

County

Social Security number (if any)

Billing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.***Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

☐

Yes

☐

No

Parent or legal guardian (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if any)

Gender:

☐

Male

☐

Female

Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English)

Preferred language read (if not English)

Primary applicant

Spouse to be covered

First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

2 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

3 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Primary applicant

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 only. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've 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.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then their 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. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 3 dependents 18 and older signing, please attach a copy of this page with the additional signatures. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- 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.
- **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 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.**

X	<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Primary applicant (parent or legal guardian for children under 18)	
X	<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Spouse	
X	<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Dependent (18 and older)	
X	<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Dependent (18 and older)	
X	<input type="text"/>	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Dependent (18 and older)	

Primary applicant

STEP 7: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options (choose one) ☐ Credit card ☐ Debit card ☐ Electronic payment ☐ Check ☐ Money order

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's payment amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Date (mm/dd/yyyy)

Account holder's signature

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

To pay with a credit or debit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Expiration date (mm/yyyy)

Card number

X

Date (mm/dd/yyyy)

Cardholder's signature

Automatic monthly payments (optional)

To cancel or update automatic payments, go to kp.org/payonline or call Member Services at 1-800-777-7902.

Do you want to sign up for automatic monthly payments?

☐ Yes☐ I want to enter a new payment method here. (Please fill out this page.)☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)☐ No, I don't want automatic monthly payments. (Skip this page.)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State ZIP code

Automatic payment options (choose one) ☐ Credit card (debit cards can't be used) ☐ Electronic payment

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Date (mm/dd/yyyy)

Account holder's signature

To pay with a credit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Expiration date (mm/yyyy)

Card number

X

Date (mm/dd/yyyy)

Cardholder's signature

Primary applicant

For applicants using a broker or Kaiser Permanente representative

If a broker or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The broker may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Note: Premiums are the same whether or not you use a broker or Kaiser Permanente representative.

To be completed by your broker or representative after you complete this application:

Firm name

Firm ID number

General agency name

General agency ID number

Broker or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone

Fax

Email address

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

X

Date (mm/dd/yyyy)

Broker or Kaiser Permanente representative

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**)፡

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**)፡

Bàsɔ̀̀ Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ Bàsɔ̀̀-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò béìn m̀ gbo kpáa. **Đá 1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902 (TTY: 711)** تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902 (TTY: 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902 (TTY: 711)**.

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902 (TTY: 711)**.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902 (TTY: 711)**.

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902 (TTY: 711)** पर कॉल करें।

Igbo (Igbo) NRUBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijiri gi. Kpọọ **1-800-777-7902 (TTY: 711)**.

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902 (TTY: 711)**.

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902 (TTY: 711)** まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902 (TTY: 711)** 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíłnih **1-800-777-7902 (TTY: 711)**.

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902 (TTY: 711)**.

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902 (TTY: 711)**.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902 (TTY: 711)**.

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902 (TTY: 711)**.

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902 (TTY: 711)**.

اردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-800-777-7902 (TTY: 711)**.

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902 (TTY: 711)**.

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902 (TTY: 711)**.

