COLORADO UNIFORM **INDIVIDUAL** APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____					
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)				

* Proof of eligibility for special enrollment will be required – information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage

Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage

Name First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."
Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION		
Is any applicant enrolled in Medicare?	☐ Yes	☐ No
Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.		
Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No
Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.		

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the 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.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID #(NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ Date Signed: _____

KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- The DORA (Department of Regulatory Agencies) Uniform Application and the KPIF Enrollment Form together are the application for health coverage. You must submit both forms and your first month's premium payment to Kaiser Permanente.
- 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 Colorado service area.

Who should not use this application?

- 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 Connect for Health Colorado at connectforhealthco.com.
- To make changes to your existing KPIF account, call **1-800-632-9700.**

Things to remember

- 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. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** for instructions.
- 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.
- Bronze, Silver, and Gold KPIF plans include pediatric dental benefits for children until the end of the month they turn age 19. KPIF plans don't include adult dental benefits. If you need dental coverage for anyone 19 and older, you should buy a separate adult dental plan from Connect for Health Colorado or another carrier.
- Remember, enrolling in a new plan 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, and proof of your qualifying life event (if required). Send these materials by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23127
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-855-355-5334**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-494-5314** (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 Colorado, 10350 E. Dakota Ave., Denver, CO 80247.

Primary applicant

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 within 30 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or civil union partnership
- ☐ 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:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ 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:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Initial confirmation of pregnancy by a health care practitioner

  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The first day of the month in which pregnancy is confirmed
  - ☐ The first day of the month after we receive the application
- ☐ Permanent relocation with access to new plans
- ☐ Determination by Department of Insurance Commissioner of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution to COBRA premium
- ☐ Loss of short-term health coverage
- ☐ Release from incarceration
- ☐ Change in income changing your eligibility for federal financial assistance through Connect for Health Colorado
- ☐ Determination by Connect for Health Colorado of exceptional circumstances
- ☐ Contract violation

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.

Primary applicant

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. Choosing a health plan is based on your county. See the county list below to determine which health plans are available to you. Your county may appear multiple times.

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park, and Teller

Plans available:

- ☐ KP Select CO Bronze 6500/50
- ☐ KP Select CO Bronze 6500/35%/HSA
- ☐ KP Select CO Bronze 7500/60 RX Copay
- ☐ KP Select CO Bronze 8500/50
- ☐ KP Select CO Catastrophic*
- ☐ KP Select CO Silver 2200/25 X
- ☐ KP Select CO Silver 4500/30 RX Copay X
- ☐ KP Select CO Silver 3700/20%/HSA X
- ☐ KP Select CO Silver 5000/25 X
- ☐ KP Select CO Silver 6000/30 X
- ☐ KP Select CO Gold 0/25 RX Copay
- ☐ KP Select CO Gold 1500/20
- ☐ KP Select CO Gold 2000/20

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, and Weld

Plans available:

- ☐ KP CO Bronze 6500/50
- ☐ KP CO Bronze 6500/35%/HSA
- ☐ KP CO Bronze 7500/60 RX Copay
- ☐ KP CO Bronze 8500/50
- ☐ KP CO Catastrophic*
- ☐ KP CO Silver 2200/25 X
- ☐ KP CO Silver 4500/30 RX Copay X
- ☐ KP CO Silver 3700/20%/HSA X
- ☐ KP CO Silver 5000/25 X
- ☐ KP CO Silver 6000/30 X
- ☐ KP CO Gold 0/25 RX Copay
- ☐ KP CO Gold 1500/20
- ☐ KP CO Gold 2000/20

Available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld

Plans available:

- ☐ KP Colorado Option Bronze
- ☐ KP Colorado Option Silver X
- ☐ KP Colorado Option Gold

***For applicants under 30 or with hardship exemptions**

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who 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 are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

The Kaiser Permanente Catastrophic plan does not include pediatric dental benefits. If you are applying for this plan and have children under age 19 who will be covered, you must purchase pediatric dental coverage separately.

- ☐ I do not have children under age 19 who will be covered under this plan.
- ☐ I hereby attest that I have or will purchase pediatric dental essential health benefit (EHB) coverage.

X _____

Applicant's signature

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* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-632-9700,** or contact your broker.

Primary applicant

STEP 3: Employer information

You must complete the "Employer information" section below.

You will not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer unless you submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the past 12 months. To see if this applies to you, please answer the following questions. If left blank, your enrollment form will not be processed until you provide the responses to the questions.

1. Will an employer of 100 or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

   ☐ Yes (subscriber) ☐ No (subscriber)

If you answered Yes, please continue to question 2. If you answered No, please continue to Step 4.

2. If the employer will be reimbursing an employee through a health reimbursement arrangement, does it qualify as a "qualified small employer health reimbursement arrangement" or QSEHRA or an individual coverage health reimbursement arrangement?*

   ☐ Yes (subscriber) ☐ No (subscriber)

3. Did the employer have a small group health benefit plan providing coverage to any employee in the 12 months prior to the date of this request for enrollment?

   ☐ Yes (subscriber) ☐ No (subscriber)

If the answer to both questions 1 and 3 is Yes and the answer to question 2 is No, the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

You (the applicant) must submit a signed affidavit from your employer, IF:

The answer to questions 1 and 2 is Yes and the answer to question 3 is No

OR

The answer to question 1 is Yes and the answer to questions 2 and 3 is No

The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier. The employer affidavit form to be completed by the employer is at the back of this enrollment form.

*Employers are required by 26 U.S.C. 9831(d)(4) to provide employees written notice regarding QSEHRAs.

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

Last name

Former medical record number (if any)

State (if any)

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address

Parent or legal guardian

Please complete this section if the primary applicant is a child under 18. The parent or legal guardian must be 18 or older.

First name

MI

Last name

Gender:

☐ Male ☐ Female ☐ X

Social Security number (if any)

Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English)

Preferred language read (if not English)

Spouse/civil union partner to be covered

A civil union partner is a person registered and legally recognized as your civil union partner by the state of Colorado or another state.

First name

MI

Choose one:

☐ Spouse ☐ Civil union partner

Last name

Former medical record number (if any)

State (if any)

Primary applicant

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

Former medical record number (if any)

State (if any)

Relationship to primary applicant

2 First name

MI

Last name

Former medical record number (if any)

State (if any)

Relationship to primary applicant

3 First name

MI

Last name

Former medical record number (if any)

State (if any)

Relationship to 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 (mobile phone if available)

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)

Primary applicant

STEP 6: Replacement of coverage information

Please note the following:

- You normally do not require more than one of the same type of policy.
- If you purchase this Kaiser Permanente health plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Health First Colorado (Colorado's Medicaid Program) or Medicare and may not need an individual health plan. If you are eligible for Medicare, you may want to purchase a Medicare supplemental plan.
- If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through Health First Colorado.

If you filled out the "Current Medical Coverage" section in the DORA Uniform Application indicating you or any of the applicants listed on this application currently have health coverage, please answer the following questions:

Do you intend to replace your current health coverage with the Kaiser Permanente health plan you're applying for? ☐ Yes ☐ No

If Yes, what is the reason you're replacing your current coverage with this Kaiser Permanente health plan?

☐ Additional benefits

☐ Fewer benefits and lower premiums

☐ No change in benefits, but lower premiums

☐ Other (please specify) _____

If you're covered for medical assistance through Health First Colorado, are you covered as:

☐ Specified Low-Income Medicare Beneficiary (SLMB) ☐ Qualified Medicare Beneficiary (QMB) ☐ Other Medicaid medical benefits

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Primary applicant

STEP 7: Sign the application agreement

Important: The primary applicant 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 your signature is missing, we will cancel the application. 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 have provided true and correct answers to all the questions on this application, to the best of my knowledge. I understand that my answers, together with the information I provided in the DORA Uniform Application, are the basis for the Kaiser Permanente for Individuals and Families health plan that is issued.
- If I worked with a broker, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the broker or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- 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* for a particular plan, please go to **kp.org/plandocuments**, or contact your broker.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

X

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

Date (mm/dd/yyyy)

/ /

Primary applicant

STEP 8: 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) ☐ Electronic payment ☐ Check ☐ Money order ☐ Credit card ☐ Debit card

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

Account holder's signature

Date (mm/dd/yyyy)

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

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

Primary applicant

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-866-437-2972.**

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)

☐ Electronic payment ☐ Credit card (debit cards can't be used)

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

Account holder's signature

Date (mm/dd/yyyy)

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

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

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.

Our standard compensation is $18 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

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:

Agency name

Agency ID number

If submitting through a general agency, please check the box indicating the agency and enter the vendor number.

☐ Warner Pacific ☐ BenefitMall

General agency ID number

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

Address

City

State

ZIP code

Phone (mobile phone if available) - - -

Fax - - -

Email address

Primary applicant

Employer Affidavit

Applicant information

This form is for applicants with an employer who has 100 or fewer employees and will be paying for or reimbursing the applicant for all or part of his or her insurance premiums.

Name (first, middle, last) (please print)

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

City

State ZIP code

Home phone - -

Work phone - -

Date of birth (mm/dd/yyyy) / /

Have your employer (or his or her representative) sign this affidavit to certify that your employer has not had a small group health benefit plan providing coverage to any employee in the past 12 months.

Mail your completed affidavit to:
Kaiser Permanente
California Service Center – KPIF
P.O. Box 23217
San Diego, CA 92193-9921

Or send it by secure fax to **1-855-355-5334.**

The undersigned officer or principal of the employer certifies that:

1. The employer is a small business employer as defined in § 10-16-102(40), C.R.S., with 100 or fewer eligible employees.
2. The employer has not had in place a small group health benefit plan for the 12 months prior to the execution of this affidavit.
3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Employer information

Company

Street address

City

State ZIP code

X

Employer representative

Date (mm/dd/yyyy) / /

Printed name

Position

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (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 **1-800-632-9700** (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 at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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**, (TTY **1-800-537-7697**). Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (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 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (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。**1-800-632-9700**（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. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (TTY **711**).

This page is intentionally left blank.

KAISER PERMANENTE®