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 Foundation Health Plan of Washington (KFHPWA) plan.

- If you want coverage for your family on the same KFHPWA 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 KFHPWA coverage, you must live in our Washington service area – Benton, Columbia, Franklin, Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, and Yakima counties.

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 KFHPWA coverage. Please visit **kp.org/wa/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 Washington Healthplanfinder at **wahealthplanfinder.org**.
- To make changes to your existing KFHPWA account, call **1-800-290-8900** (TTY **711**).

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** (TTY **711**) 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.
- 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 Foundation Health Plan of Washington
  Membership Administration
  P.O. Box 23127
  San Diego, CA 92193-9921

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

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 producer, please call them for assistance.

All medical plans are offered and underwritten by Kaiser Foundation Health Plan of Washington, 2715 Naches Ave. SW, Renton, WA 98057.

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 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

☐ Loss of minimum essential health coverage (write the last full day you had coverage)*

Did you lose coverage with us (KFHPWA) that was provided by your employer?

☐ Yes ☐ No

If Yes, you have 2 options for continuing your coverage with us

☐ Coverage that begins automatically the day after your employer coverage ends

☐ Coverage that begins based on when we receive your application. Please see **kp.org/specialenrollment** under "Loss of minimum essential health coverage" for more details

☐ Gaining or becoming a dependent through marriage or domestic 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

☐ 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

☐ Permanent relocation with access to new plans

☐ Determination by Washington Healthplanfinder 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 or government subsidization of COBRA premiums

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

*If your qualifying life event is loss of KFHPWA coverage, we may review membership records to check when and why you lost coverage.

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.

☐ Bronze	☐ Silver HSA	☐ VisitsPlus Gold
☐ Bronze HSA X	☐ VisitsPlus Silver HD	
☐ VisitsPlus Bronze		

For information about health benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-290-8900** (TTY **711**), or contact your producer.

STEP 3: Choose your optional dental plan

You can choose to add dental coverage from Delta Dental of Washington for an additional monthly charge. An adult/family basic plan is available for adults and dependents 25 and younger. To cover children only, a pediatric plan is available for family members 18 and younger. Under the Affordable Care Act, pediatric dental coverage is required. If your application includes children 18 and younger and you don't enroll them in our pediatric dental plan, we'll contact you to submit an Attestation of Pediatric Coverage with proof of other pediatric dental coverage. For information about dental benefits and costs, please review your enrollment materials.

Dental coverage is provided by Delta Dental of Washington, 400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371. For more information, go to **deltadentalwa.com/group/kaiserpermanente**, call **1-800-290-8900** (TTY **711**), or contact your producer.

☐ Yes, I'd like to enroll in a dental plan.	If Yes, please select your dental plan.	☐ Pediatric Dental #09140
☐ No, I'm not interested in dental coverage.		☐ Adult/Family Basic Dental #09145

Primary applicant

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 health record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

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

City

State | ZIP code | County | Phone (mobile phone if available)

Mailing address ☐ Check if same as home address

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address

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

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

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 | Date of birth (mm/dd/yyyy)

Last name

Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Preferred language spoken (if not English) | Preferred language read (if not English)

Primary applicant

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by Washington state. Washington state registered domestic partners are treated the same as a spouse.

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

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. Dependent children are eligible to enroll through the age of 25.

1 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

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 | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

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

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. Dependent children are eligible to enroll through the age of 25.

3 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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

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)

STEP 6: 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 KFHPWA 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.
- If I worked with a producer, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the producer or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. I acknowledge by my signature that the information I have supplied on this form is true and correct.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

X _____ Date (mm/dd/yyyy)

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

Primary applicant

STEP 7: Enter first month's payment details

If you do not send payment with your application, you will receive an invoice. You must pay your first month's premium by the due date or your application will be canceled and you will not have coverage.

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 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

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 **1-800-290-8900** (TTY **711**).

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 producer or Kaiser Permanente representative

If a producer 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 producer may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Our standard compensation is $240, per member per year, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

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

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

Agency name

Agency ID number

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

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone (mobile phone if available)

Fax

Email address

I (the producer/Kaiser Permanente representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the *Evidence of Coverage* except through written materials furnished by KFHPWA. The applicant has been informed that the effective date of coverage is assigned by KFHPWA. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

☐ Yes ☐ No

X

Producer or Kaiser Permanente representative

Date (mm/dd/yyyy)

Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them less favorably because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity. We also:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Services at **1-888-901-4636** (TTY **711**).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator at P.O. Box 35191, Mail Stop: RCR-A1N-22, Seattle, WA 98124-5191 or by calling **1-888-901-4636** (TTY **711**). You can file a grievance in person or by mail, phone, or online at **kp.org/wa/feedback**. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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, 800-537-7697** (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

Español (Spanish): ATENCIÓN: Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636** (TTY **711**).

中文 (Chinese)：注意：如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636** (TTY **711**)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636** (TTY **711**).

한국어 (Korean): 참고: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636**(TTY **711**)번으로 문의하십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636** (TTY **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636** (TTY **711**).

ភាសាខ្មែរ (Khmer)៖ សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636** (TTY **711**)។

日本語 (Japanese): 注意事項：無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636** (TTY **711**) まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማሳሰቢያ፥ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እገዛ አገልግሎቶች፣ በነጻ ለእርስዎ ይቀርባሉ፡ ወደ **1-888-901-4636** (TTY **711**) ይደውሉ።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa yoo ta’e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636** (TTY **711**) irraatti bilbilaa.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636** (TTY **711**) ‘ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): انتباه:إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً.
اتصل بالرقم **1-888-901-4636** (TTY **711**)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY **711**).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ,
ການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636** (TTY **711**).

International Symbol for ASL (American Sign Language):

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