

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

## **Application for health coverage**

Individual and Family Plans

Who can use	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.
this application?	You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.
	• 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?	• 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 <b>kp.org/medicare</b> 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 Virginia's Insurance Marketplace at https://www.marketplace.virginia.gov/.
	• To make changes to your existing KPIF account, call 1-866-410-7536.
Things to remember	• If you're applying during open enrollment, the date we receive your application may change your effective date – it will 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.
	<ul> <li>If you're applying during a special enrollment period, go to kp.org/specialenrollment or call 1-800-494-5314 (TTY 711) for instructions.</li> </ul>
	<ul> <li>Please answer all questions, and type or print using ink only. Leave an empty box in betwee words, and put a hyphen in the box for hyphenated names.</li> </ul>
	<ul> <li>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.</li> </ul>
	• 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: <b>1-855-355-5334</b>
	Note: Checks must be mailed and can't be faxed.
Need help?	• For help with completing this application, please call <b>1-800-494-5314</b> (TTY <b>711</b> ).
	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 you	ır enrollment period			
Select one option: Open enro	ollment (skip to Step 2) 🔲 A spe	cial enrollm	ent period (continue below	v)
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Please write the date of your qualifyi	ng life event.		(mm/dd/yyyy)	
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STEP 2: Choose you	-			
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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.

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Parent or legal guardian	Please complete this section The parent or legal guardian	if the primary applicant is a child umust be 18 or older.	inder 18.
First name		MI	Date of birth (mm/dd/yyyy)
Last name Gender:	Social Security number (if any)		
Male Female			
Preferred language spoken (if not English		Preferred language read (if	not English)
Spouse to be covered			
First name			MI
Last name			
Date of birth (mm/dd/yyyy)			
Former medical record number (if any)	State (if any)	Gender:  Male Female	Social Security number (if any)

Primary applicant		
Dependents to be covered	If you have more than 3 dependents to be covered, please and submit it with your application.	fill out an extra copy of this page
1 First name	MI	Date of birth (mm/dd/yyyy)

Dependents to be covered	and submit it with your a	pplication.	
1 First name		MI	Date of birth (mm/dd/yyyy)
Last name			
Former medical record number (if any)	State (if any)	Gender:	Social Security number (if any)
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Relationship to primary applicant			
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Primary applicant

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If check or money order Write the name of the primary applicant on the check. Mail payment with your application to the address	s 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	Date (mm/dd/yyyy)

Cardholder's signature

Primary applicant	

## Automatic monthly payments (optional)

To cancel or update automatic payments, go to onlinebiller.com/kpmas or call Member Services at	1-800-777-7902.
	automatic monthly payments. (Skip this page.)
<ul> <li>I want to enter a new payment method here. (Please fill out this page.)</li> <li>Please use the same payment method I provided for my first month's payment. (Skip this page.)</li> </ul>	
First name of person responsible for payment	MI
Last name of person responsible for payment	
Billing address	
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Automatic payment options (choose one)	d (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	
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Account holder's first name	MI
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Primary applicant	
For applicants using a broker or Kaiser Permanent	e representative
If a broker or Kaiser Permanente representative (employee) helped you decide which plan to make sure they complete this page.  The broker may receive monetary payments or other compensation from Kaiser Permanente Our standard compensation is \$18 per member per month plus a potential bonus. To learn representative are the same whether or not you use a broker or Kaiser Permanente representative after you complete this application:	in connection with your purchase of this coverage. more, visit <b>kp.org/brokercompensation</b> . entative.
Agency name	Agency ID number
General agency name	General agency ID number

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

Kaiser Permanente-appointed ID number

Fax

National producer number (NPN)

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.

X	Date (mm/dd/yyyy)

1345183158 VA 2025

Address

City

State

**Email address** 

Yes No

Broker or Kaiser Permanente representative

ZIP code

Phone (mobile phone if available)

## 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:** የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊ*ያግ*ዝዎት ተዘጋጀተዋል፡ 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 (Arabic) 1-800-777-7902.

**Ɓǎsɔɔ̇ɔ Wùdù (Bassa) Dè dε nìà kε dyédé gbo:** Ο jǔ ké m̀ Ɓàsɔʻɔ-wùdù-po-nyɔ̀ jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য কর্ল: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন কর্ন 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 790-777-800-1 (711: 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:** O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. Kpoo **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 이용하실수 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, koji' hódíílnih 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).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-777-801 (TTY).

**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**).

