MEMBERSHIP APPLICATION FOR

# Kaiser Permanente Personal Advantage

*For a complete listing of available physicians, visit www.kp.org.*

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

For Office Use Only:

| BROKER NAME: ______________________ AGENT # | General Agency Stamp (if applicable) |
|---|---|



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**NOTE:** Applications are subject to medical review, and must be dated within 60 days of your requested effective date. Your payment must be received prior to final processing. This application may become part of your permanent medical record if your membership is approved. It may be reviewed again by you with a physician.

## INSTRUCTIONS:

- Please answer all questions completely to ensure timely processing of your application.
- Use only black or blue ink.
- Completely fill in the **O** bubbles. *Example:* ●
- Print clearly above the lines or inside the boxes.

## 1. PERSONAL INFORMATION

I hereby apply for membership in Kaiser Permanente based on the following:

**Primary Applicant** (the oldest person applying for coverage)

Select One: **O** Mr. **O** Mrs. **O** Ms. **O** Miss **O** Dr.

Last Name First Name Middle Initial

Street Address Apt. # or PO Box

City State Zip Code

Home Phone Work Phone E-mail Address

Is the billing address different than the address listed above? **O** Yes **O** No

If Yes, please list the billing address below:

Billing Street Address Apt. # or PO Box

City State Zip Code

Marital Status: **O** Single **O** Married **O** Widowed **O** Divorced

What type of coverage are you applying for? (Select only one.)

**O** Individual **O** Individual & Spouse **O** Individual & Child(ren) **O** Family (Individual, Spouse, & Child[ren])

Has any applicant ever been a Kaiser Permanente member? **O** Yes **O** No

If Yes, please write their prior Kaiser Permanente Health Record Number (HRN), if known, in the "Prior HRN" box on the next page.

Please complete the following information for each person applying. If more space is needed for additional applicants, please attach another application and complete just the information for those additional applicants. (You can print another application from our Web site, *www.kp.org/care*.)

**Primary Applicant**

| | Social Security # | Birthdate | Height | Weight | Sex | Prior HRN |
|---|---|---|---|---|---|---|
| | - - | MM/DD/YY | (ft./in.) | (lbs) | M/F | |

**Spouse**

| Last Name | First Name | MI | Social Security # | Birthdate | Height | Weight | Sex | Prior HRN |
|---|---|---|---|---|---|---|---|---|
| | | | - - | MM/DD/YY | (ft./in.) | (lbs.) | M/F | |

**Dependent 1 (D1)** Relationship - O Son O Daughter O Other ( )

| Last Name | First Name | MI | Social Security # | Birthdate | Height | Weight | Sex | Prior HRN |
|---|---|---|---|---|---|---|---|---|
| | | | - - | MM/DD/YY | (ft./in.) | (lbs.) | M/F | |

**Dependent 2 (D2)** Relationship - O Son O Daughter O Other ( )

| Last Name | First Name | MI | Social Security # | Birthdate | Height | Weight | Sex | Prior HRN |
|---|---|---|---|---|---|---|---|---|
| | | | - - | MM/DD/YY | (ft./in.) | (lbs.) | M/F | |

**Dependent 3 (D3)** Relationship - O Son O Daughter O Other ( )

| Last Name | First Name | MI | Social Security # | Birthdate | Height | Weight | Sex | Prior HRN |
|---|---|---|---|---|---|---|---|---|
| | | | - - | MM/DD/YY | (ft./in.) | (lbs.) | M/F | |

## 2. PLAN SELECTION

a) Which plan are you applying for?*

### HMO Plans

- O Premier Plan
- O Plan 500
- O Plan 1,000
- O Plan 2,000
- O Plan 3,000
- O Plan 5,000

### Multi-Choice Plans

- O Multi-Choice 1,000
- O Multi-Choice 2,000
- O Multi-Choice 3,000

### Deductible Plans with HSA Option

- O HSA Option 3,500/100% Self
- O HSA Option 5,000/100% Self
- O HSA Option 3,500/80% Self
- O HSA Option 3,500/100% Family
- O HSA Option 5,000/100% Family
- O HSA Option 3,500/80% Family
- O HSA Option 5,000/80% Family

b) Requested Effective Date of Coverage

Month________________ Day 01 Year_______

The earliest your coverage will begin is the first of the month following receipt of a completed application and first month's premium. Coverage will not be back-dated.

* *The Participating and non-Participating Provider benefit levels of Multi-Choice plans are underwritten by Kaiser Permanente Insurance Company (KPIC). The Kaiser Permanente Provider benefit level of Multi-Choice and all other plans are provided by Kaiser Foundation Health Plan of Georgia, Inc.*

## 3. MEDICAL INFORMATION

- Answer the questions below with respect to yourself and each family member applying for coverage.
- If you can answer Yes for any applicant, fill in the Yes bubble and explain further—for each person the Yes applies to—on the chart in Question 8.

Have you or any family member applying for coverage:

1. been hospitalized in the last 12 months, except for pregnancy?

   O Yes O No

2. required medical attention 6 or more times in the last 12 months, except for pregnancy?

   O Yes O No

3. within the last 3 years, been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?

   O Yes O No

4. in the last 5 years, taken or used illegal drugs or prescription drugs not prescribed by a doctor?

   O Yes O No

5. in the last 5 years, participated in or been advised to participate in a program that deals with your alcohol or substance abuse?

   O Yes O No

6. ever been treated for, or had a doctor or other health care provider advise you that you have, any of the following conditions? Please mark all that apply.

   O AIDS, ARC, HIV
   O Sexually transmitted disease
   O Hepatitis
   O Hernia not repaired
   O Back/neck pain or injury
   O Bone marrow transplant
   O Crohn's or ulcerative colitis
   O Depression or anxiety
   O Mental health condition
   O Eating disorder, anorexia nervosa/bulimia
   O Heart or valve condition
   O Asthma
   O Emphysema/COPD
   O Lung condition, other chronic condition
   O High blood pressure
   O High cholesterol
   O Kidney/bladder condition — including kidney stones
   O Liver condition or pancreas disorder
   O Gallstones
   O Anemia or other blood disorder
   O Painful or irregular menstrual cycle or female reproductive disorders
   O Lupus/SLE/inflammatory condition
   O Breast implants
   O Melanoma/breast/prostate/bladder cancer
   O Skin cancer
   O Other cancers
   O Aneurysm
   O MS/ALS/Parkinson's/Alzheimer's
   O Neurologic condition
   O Pacemaker or other implanted medical device
   O Prostate condition
   O Rheumatoid arthritis
   O Seizures/headaches requiring medical treatment
   O Sickle cell anemia
   O Diabetes
   O Stomach or intestinal problems or GI reflux
   O Stroke
   O Lumps, masses, tumors, or growths
   O Ulcer
   O Other conditions not specifically listed on application, even if not currently under treatment
   O None of the above

7. experienced unexplained and/or undiagnosed symptoms such as the following? Please check all that apply.

   O Fever
   O Swollen glands
   O Chest pain
   O Shortness of breath
   O Abdominal or pelvic pain
   O Loss of consciousness
   O Unexplained weight loss
   O Rectal bleeding
   O Loss of appetite
   O Dizziness
   O Chronic fatigue
   O Rash/skin problems
   O Skin lesions
   O Lumps
   O Other ________________________________________
   O None of the above

8. If you indicated a Yes answer for any of the items in **questions 1-7**, please explain below.
If additional space is needed, list the information on a separate sheet of paper and attach it to this application.

| Question Number | Person Treated | Explanation/Name of Illness or Disorder | Type of Treatment Received/Pending | Treatment Dates From | To | Name and Address of Attending Physician |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |
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| | | | | | | |

9. (a) Are you <u>or any family member applying for coverage</u> regularly taking any prescription medications?

**O** Yes **O** No

(b) If Yes, please explain below. If additional space is needed, list the information on a separate sheet of paper and attach it to this application.

| Person Treated | Name of Medication | Dosage/ Frequency | Treatment Dates From | To | Name and Address of Attending Physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

Answer the questions below for yourself and each family member applying for coverage. (D1, D2, and D3 should correspond to the Dependents you listed under Additional Applicants in the Personal Information section.) Choose the one most appropriate answer for each person applying and mark an **X** in that box. Write in numeric answers when asked.

10. (a) If you have ever smoked cigarettes, what is or was your average daily usage?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| ½ pack or less | | | | | |
| 1 pack | | | | | |
| 1½ packs | | | | | |
| 2 or more packs | | | | | |
| N/A | | | | | |

(b) For how long?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| 9 years or less | | | | | |
| 10-14 years | | | | | |
| 15-19 years | | | | | |
| 20-29 years | | | | | |
| Over 30 years | | | | | |
| N/A | | | | | |

(c) Have you quit?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Yes | | | | | |
| No | | | | | |
| If so, when? | MM/YY | MM/YY | MM/YY | MM/YY | MM/YY |

11. (a) Have you consumed more than 10 alcoholic beverages per week within the last 6 months?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Yes | | | | | |
| No | | | | | |

(b) If Yes for 11 (a), write in the number of drinks consumed weekly.

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Beer | | | | | |
| Wine | | | | | |
| Hard liquor | | | | | |

12. Are you currently taking birth control medication, estrogen, Premarin, Depo-Provera, etc.?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Yes | | | | | |
| No | | | | | |

13. Are you an expectant parent or do you have a pending adoption?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Yes | | | | | |
| No | | | | | |

14. For females over age 11 only:

(a) Are you pre-menstrual (have never menstruated), post-menopausal, or have you had a hysterectomy or tubal ligation?

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Yes | | | | | |
| No | | | | | |

(b) If No, date of your most recent normal menstrual period:

| Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|
| MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY |

For Office Use Only:

Approved/Denied Code ____________________ Effective Date ____________________

______________________________________________________________________________

## 4. APPLICATION AGREEMENT

I hereby apply for enrollment for myself and eligible family dependents listed on this form, and I agree that the information listed is correct. Upon acceptance to the Health Plan, my enclosed check for the first month's premium will be deposited or my credit card charged, and my coverage will begin on the first day of the month as assigned by Health Plan.

I authorize Kaiser Foundation Heath Plan of Georgia, Inc. (Kaiser Permanente) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Personal Advantage Program. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Personal Advantage Program, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Personal Advantage member, I understand that Kaiser Permanente and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Kaiser Permanente and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy. I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Heath Plan of Georgia, Inc., Personal Advantage Underwriting Department, 3495 Piedmont Road, Atlanta, Georgia, 30305.

**NOTICES:**

**1.** Any intentional material misstatement or omission of information may void your coverage and/or the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

**2.** YOU MUST IMMEDIATELY INFORM US if your health status or current medication changes at any time before your membership in Personal Advantage becomes effective. Failure to inform us of such changes can void your membership. You can choose to update your application information by telephone (404) 364-7001, by fax (404) 365-4146, or by writing us at Kaiser Permanente Personal Advantage; 3495 Piedmont Road, NE; Building 9; Atlanta, GA 30305. All written and fax correspondence must be signed and dated.

**3.** After the effective date of this coverage, Health Plan may rescind your coverage and your dependent's coverage retroactively to the effective date (1) based on updated information, (2) upon learning that you failed to provide updated information, OR (3) upon learning that you intentionally provided any incorrect or incomplete answers on this application or in communications regarding it. If your coverage is rescinded, you will be billed for all services you received.

**4.** Georgia residents who do not qualify for Personal Advantage and are not current Kaiser Foundation Health Plan members may be eligible to participate in the State of Georgia Health Insurance Assignment System, a state-sponsored guaranteed-issue health care coverage program in which Kaiser Permanente participates. Georgia residents who do not qualify for Personal Advantage and who are current Kaiser Foundation Health Plan members can choose to be considered for our conversion products, one of which is available to HIPAA-qualified individuals. If you wish to exercise that option, please contact our Customer Service Department at (404) 261-2590 to obtain an application.

**TO THE APPLICANT:** You or your authorized representative may request a copy of your completed application. For more information, please call (404) 364-7001.

I authorize the disclosure of premium billing, claim payment, and commission information to my broker of record and my spouse (if applicable) to expedite the servicing of my account. **O** Yes **O** No

**IMPORTANT:** Please read the conditions above, and sign and date below. **All applications MUST be signed and dated by Primary Applicant, Spouse (if applicable), and any Dependent 18 years of age or older (if applicable). I have read and understand all of the above conditions and terms.**

| | | | |
|---|---|---|---|
| Signature of Primary Applicant | Date | Signature of parent or guardian if Primary Applicant is under 18 | Date |
| Signature of Spouse | Date | Signature of Dependent if 18 years of age or older | Date |

## 5. PAYMENT OPTIONS

O **Automatic Draft Plan** Your most convenient and reliable option is this payment method. Payments are automatically deducted from your checking or savings account on the fifth day of each month. To enroll, simply read and fill out the section below. BE SURE TO INCLUDE A VOIDED CHECK.

**Note:** *If you choose the Automatic Draft Plan as your payment option, you are still required to send your first month's premium along with a voided check. The automatic draft plan takes effect in your second month of coverage.*

I hereby authorize Kaiser Foundation Health Plan of Georgia, Inc., (Health Plan) to debit my checking or savings account with the financial institution named below. If a debit will differ from that of the previous month's debit, Health Plan will notify me in writing at least seven days in advance of the change.

This authority is to remain in full force and effect until Health Plan has received written notification from me of its termination in such time and in such manner as to afford Health Plan reasonable opportunity to act on it. (Must give Health Plan 30 days.)

If an entry is erroneously initiated by Health Plan to my account, I have the right to have the amount of the entry credited to my account. However, I must give the financial institution a written notice within 15 days explaining that the entry was in error.

Bank Name: ______________________ Member (Depositor) Account Number: ______________________

Bank Address: ______________________________ Type of account (check one) O Savings Account O Other O Checking Account *(Please attach a voided check)*

______________________________

Member Name(s): ______________________________
*(Please Print)*

Signed: ______________________________
*(Member Signature)*

Date: ____________ Signed: ______________________________
*(Depositor Signature)*

Date: ____________ Signed: ______________________________
*(2nd Depositor Signature if Joint Account)*

O **Payment by Credit Card** Your credit card will be charged for your/your family's first month's premium. Also, each month's premium will be automatically charged to your credit card at the beginning of every month unless you arrange another form of payment by calling (404) 364-7179. Your credit card will be charged only if you are accepted for membership.

Type of card: ______________ Credit card number: ______________ Expiration date:

Name as it appears on card: ______________________ Signature: ______________________

O **Payment by Monthly Invoice** You will receive a monthly invoice from Kaiser Permanente. Payment is due on or before the first day of each month. If payment is not received by this date, you are subject to termination of membership.

**Note:** *If you choose the Payment by Monthly Invoice option, you are still required to send your first month's premium.*

***If you do not choose a payment method, you will automatically receive a monthly invoice. You are still required to send your first month's premium.***

### What if all family members are not accepted?

Please remember that Kaiser Permanente's Personal Plans are individually underwritten. Each family member must pass a medical review. It is possible that some or all family members may not be accepted. In the event that all family members are not accepted, please instruct us how to handle accepted family members:

O Please enroll any accepted family members.

O Please cancel the enrollment process for any accepted family members and return my first month's premium check.