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

Application for health coverage

Who can use this application?

You may use this enrollment application to apply for individual or family coverage provided by Kaiser Permanente.

- If you want coverage for your family on the same Kaiser Permanente plan, please complete one application for the family.
- If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for Kaiser Permanente coverage, you must live in our Maryland service area unless you are a child attending school outside of the service area, or as otherwise required by law.
- If you qualify for federal financial assistance to help pay for copayments, coinsurance, deductibles, or premiums, do not complete this form. You must apply for coverage through Maryland Health Connection at **marylandhealthconnection.gov**.

Apply faster online

- You can apply faster online at **buykp.org/apply**.
- If you would like to communicate with us electronically, please apply online and set up a secure email account.

Things to remember

- Please answer all questions and type or print using ink only.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you are applying during a special enrollment period and would like additional information, please see the "When and how to enroll in your plan" section in the *Enrollment Guide*, or call us at **1-800-494-5314** or contact your agent or broker.
- If you have a current Kaiser Permanente plan that was purchased directly from Kaiser Permanente and would like to change plans, please call **1-800-494-5314** instead of filling out this application.
- To avoid being double billed, if you are enrolled in a plan through **marylandhealthconnection.gov**, you should cancel that plan through **marylandhealthconnection.gov** before the effective date of your new plan purchased directly from Kaiser Permanente. It is your responsibility to make sure that the effective date of your cancellation does not result in a lapse in coverage.
- **Make sure your application is complete, signed, and includes your first month's premium payment. If your application is incomplete or does not include your first month's payment, it may delay your enrollment effective date or your application may be canceled.**
- Send your complete, signed application and payment by mail or fax:

  Mail your signed application to:
  Membership Administration Dept./KPIF 5W
  Kaiser Permanente
  Suite 100
  2101 East Jefferson St.
  Rockville, MD 20852-9995

  Or send it by secure fax to:
  Kaiser Permanente for Individuals and Families: **301-388-1615**

Need help?

- For help completing this application, please call **1-800-494-5314.**
- **We will provide language assistance at no cost to you.**
- If you are working with an agent or a broker, please call him or her for assistance.

Step 1: Tell Us When You're Applying

Select one option: ○ Open enrollment (11/15/14 to 2/15/15) ○ A special enrollment period

Please complete this section if you are applying during a special enrollment period outside of the open enrollment period of November 15, 2014, through February 15, 2015.

For enrollment during a special enrollment period, subscribers and their dependents may enroll or change health plans following a triggering event, as defined below. This enrollment application and payment of first month premium must be received by Kaiser Permanente within 60 days of the triggering event, unless stated otherwise below. To complete your application for processing for your special enrollment period, we need a signed letter from you describing the triggering event and the triggering event date. Your letter must be received by us at the address shown on page one within 10 days following our receipt of your completed application. If we don't receive a letter within 10 calendar days, we will cancel your application. You may reapply and submit the letter regarding your triggering event, but you must do so within the 60-day special enrollment period.

Please indicate the type of triggering event by checking the appropriate triggering event below.

Provide date of triggering event: (mm/dd/yyyy) _____

○ Loss of minimum essential coverage* – NOTE: This does not apply when termination or loss or coverage is due to (a) failure to pay premiums on a timely basis, including COBRA coverage premiums prior to expiration of COBRA coverage or (b) situations allowing for a rescission as specified by law, which involve an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

Examples of possible valid reasons for loss of minimum essential coverage (this list is not exhaustive):

- Exhaustion of COBRA coverage
- Legal separation or divorce
- Termination of employment, loss of employer contributions, or reduction of hours resulting in loss of employer coverage or loss of qualification for employer coverage
- Termination of employer contribution resulting in loss of coverage
- Death of subscriber

The date of the loss of coverage is the last day the individual or dependent would have coverage under his or her previous health plan.

○ Gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, or placement for foster care

○ Enrollment or nonenrollment in a qualified health plan as evaluated by the Maryland Health Connection is determined to be (a) unintentional, inadvertent, or erroneous; and (b) the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Maryland Health Connection or HHS.

○ Individual or his/her dependent enrolled in a qualified health plan (QHP) in the Maryland Health Connection adequately demonstrates to the Maryland Health Connection that the QHP substantially violated a material provision of contract in relation to the individual (Maryland Health Connection must make this determination).

○ Individual (or dependent enrolled in the same health plan) is determined newly eligible, or newly ineligible, for advance payments of federal premium tax credits, or other change in eligibility for federal cost-sharing reductions.

○ Determination by Maryland Health Connection that an individual or his/her dependents:

- was not enrolled in QHP coverage;
- was not enrolled in the QHP selected by the qualified individual or enrollee; or
- is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non–Maryland Health Connection entity providing enrollment assistance or conducting enrollment activities

○ A permanent move into the service area of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s service area

○ An individual or dependent who is enrolled in an employer-sponsored health benefit plan that is not qualifying coverage is determined newly eligible for advance payments of the premium tax credit and is allowed to terminate existing coverage.*

○ Individual or dependent loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and(a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the individual or dependent would have pregnancy-related coverage.*

○ Individual or dependent loses medically needed coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the individual or dependent would have medically needed coverage.*

○ Individual or his/her dependent enrolled in a non-calendar year plan (an individual plan with a contract year that ends on a date other than December 31) has reached the end of their 2014 contract year. The date of the loss of coverage is the date in 2014 of the expiration of the non-calendar year plan.*

Please call **1-800-494-5314** to determine the effective date of coverage for your enrollment.

Step 2: Choose Your Health Plan

Choose one Kaiser Permanente health plan. If any family members are applying for different health plans, please submit a separate application form for each plan.

Bronze	Silver	Gold	Platinum
○ KP MD Bronze 4500/50/Dental/PedDental	○ KP MD Silver 1500/30/Dental/PedDental	○ KP MD Gold 0/20/Dental/PedDental	○ KP MD Platinum 0/10/Dental/PedDental
○ KP MD Bronze 4500/50/HSA/Dental/PedDental	○ KP MD Silver 2500/30/Dental/PedDental	○ KP MD Gold 1000/20/Dental/PedDental	
○ KP MD Bronze 5000/30%/HSA/Dental/PedDental	○ KP MD Silver 1750/25%/HSA/Dental/PedDental		

CATASTROPHIC PLAN

We also offer a Catastrophic plan, a high-deductible plan option for applicants under age 30 and certain persons age 30 and older. If you or any family members are age 30 or older, each person may only apply for this plan if you submit, with your completed application, evidence of eligibility for each person, in the form required by Kaiser Permanente, demonstrating a lack of affordable coverage or financial hardship.

○ KP MD Catastrophic 6600/0/Dental/PedDental

For information describing the benefits and limitations, cost-sharing amounts, premiums, dental plans, and enrollment periods, please review the details in your enrollment materials. To request a copy of the *Membership Agreement* for a particular plan, please call **1-800-494-5314** or contact your agent or broker.

Enhanced Dental HMO Rider†

Dental coverage is included in your health plan for all members 18 and younger. We also offer an optional dental plan for adults 19 and older. Please choose 1 option below.

○ Yes. I would like to enhance my dental coverage by selecting a Dental HMO rider for each adult age 19 and older who is applying for coverage.

○ No. I am not interested in the optional adult dental coverage.

*You and your dependent have 60 days before and after the loss of coverage to enroll in or change health plans.

†Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente), and administered by Dominion Dental Services USA, Inc. (Dominion).

If you qualify for federal financial assistance, do not use this form. We can help you apply through marylandhealthconnection.gov.

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Primary applicant ____________________

Step 3: 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.

Check one of the following to indicate the level of coverage you are seeking: ○ Adult(s) ○ Adult(s) and child(ren) ○ Child(ren)-only

Name (first, middle, last)					
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)		
Street address (no P.O. boxes, please)				Apt. number	Same as billing address? ○ Yes ○ No
City		State	ZIP	County	
Main phone ( ) –	Other phone ( ) –	Preferred language spoken (if not English)	Preferred language read (if not English)		

Spouse/Domestic Partner to Be Covered

A domestic partner is a person registered and legally recognized as your domestic partner by Maryland.

Name (first, middle, last)			
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

Dependents to Be Covered

If you have more than 5 dependents to be covered, attach another application and complete just the information for those applicants.

Name (first, middle, last)			Relationship to primary applicant
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Name (first, middle, last)			Relationship to primary applicant
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Name (first, middle, last)			Relationship to primary applicant
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Name (first, middle, last)			Relationship to primary applicant
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
Name (first, middle, last)			Relationship to primary applicant
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

Step 4: Identify Financially Responsible Party

To be completed by the parent or legal guardian if the applicant is under age 18. The primary applicant, if age 18 or older, is considered financially responsible.

Name (first, middle, last)				Gender ◯ M ◯ F	Date of birth (mm/dd/yyyy)
Same address as primary applicant? ◯ Yes ◯ No If no, fill in your address below.	Relationship to applicant: ◯ Parent/Legal guardian ◯ Spouse/Domestic partner ◯ Other:				
Street address (no P.O. boxes, please)					Apt. number
City		State	ZIP	County	
Main phone ( ) –	Other phone ( ) –	Preferred language spoken (if not English)		Preferred language read (if not English)	

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. This person is called an *authorized representative*.

Name of authorized representative (first, middle, last)			
Street address (no P.O. boxes, please)			Apt. number
City	State	ZIP	County
Phone ( ) –			
By signing, you allow this person to sign your application, to get official information about this application, and to act for you on matters related to this application.			
Primary applicant or financially responsible party (parent or legal guardian for applicants under 18) X			Date (mm/dd/yyyy)

Step 6: Sign the Application Agreement

Important: All applicants and dependents 18 or older must read and sign below. If the primary applicant is younger than 18, then his or her parent or legal guardian must sign. By signing, the financially responsible party agrees to be responsible for paying all premiums, copayments, coinsurance, and deductibles for all the applicants listed on this form. If signatures are missing, we cannot continue processing the application.

All faxed and mailed correspondence must be signed and dated by the applicant or someone legally authorized to act on his or her behalf. The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **301-468-6000** or **1-800-777-7902.**

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- I know that under federal and state law, discrimination isn't permitted on the basis of race, color, national origin, disability, age, sex (gender), or religion. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, cancellation of coverage, and/or denial of insurance benefits.

I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.

I hereby enroll in a Kaiser Permanente for Individuals and Families Plan, underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan). I certify that the representations made herein are true and accurate to the best of my knowledge and belief. I understand that the subscriber or, for a child-only request, the parent/legal guardian, will be financially responsible under this agreement.

The answers provided in this application are representations and not warranties. I hereby certify that I have read and understand all of the above terms and conditions and that the answers I have provided in this application are true and complete to the best of my knowledge and belief.

This document shall be part of any contract and be the basis for any contract issued.

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 301-468-6000 or 1-800-777-7902 before signing this application.

WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Primary applicant or financially responsible party/authorized representative (parent or legal guardian for applicants under 18) X	Date (mm/dd/yyyy)
Spouse/Domestic partner X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)
Dependent (18 or older) X	Date (mm/dd/yyyy)

Step 7: Enter Details for First Month's Premium Payment

Your application must be accompanied by payment for your first month's premium. If your payment or payment information is missing or incomplete, your application may be delayed or canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Do not send cash through the mail.

Billing Information

Complete the following information for the financially responsible party. The financially responsible party is the primary applicant unless someone else is identified in Step 4 as the financially responsible party.

Name of financially responsible party (first, middle, last)	Payment amount for your first month's premium $

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

City	State	ZIP	County

Payment Options

Check your preferred payment option below and complete that section.

◯ **CREDIT/DEBIT CARD** If you are paying by credit or debit card, please complete the following information:

Credit/Debit card information: ◯ Credit ◯ Debit	◯ Visa ◯ MasterCard ◯ Discover ◯ American Express
Cardholder's name as it appears on card	
Credit/Debit card number	Expiration date (mm/yyyy)
Cardholder signature X	Date (mm/dd/yyyy)

◯ **ELECTRONIC PAYMENT**

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ◯ Checking account ◯ Savings account	Bank name
Routing number	Account number

(At the bottom of your check, you will see 3 groups of numbers. The first group of numbers is your routing number; the second group is your account number.)

Account holder's full name (print)	Account holder signature X

◯ **CHECK** ◯ **MONEY ORDER**

If you are paying by check or money order:

- Make the check or money order payable to Kaiser Permanente.
- Write the name of the primary applicant on the check.
- Mail to the address listed on page 1.

Step 8: Sign Up for Automatic Monthly Payments

For your convenience, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

Billing Information

Same billing as first month's premium? ◯ Yes ◯ No If no, complete the following information for the financially responsible party.

Name of financially responsible party (first, middle, last)		
Street address (no P.O. boxes, please)		**Apt. number**
City	**State**	**ZIP**

Payment Options

I hereby authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), to initiate debit entries for the monthly premium amount from my checking, savings, or credit card account as indicated on this form. This authorization is to remain in effect until Health Plan has received written notification from me of its termination and in such manner as to enable Health Plan reasonable opportunity to act. If an entry made by Health Plan to my account results in an overcharge, I have the right to have that charge credited to my account by Health Plan. Within 30 calendar days following the date the financial institution sent or made available to me a statement of account or notification pertaining to the erroneous entry, I must mail or fax to Health Plan a written notice identifying the entry, stating that the entry was in error, and requesting that Health Plan credit my account or issue a refund for the amount charged in error.

Please continue to make payments by invoice until you receive written notice from Health Plan of the date when the first automated deduction will be effective.

◯ DEDUCT FROM MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on the first day of each month and agree to the terms outlined above.

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ◯ **Checking account** ◯ **Savings account**	**Bank name**
Routing number	**Account number**

(At the bottom of your check, you will see 3 groups of numbers. The first group of numbers is your routing number; the second group is your account number.)

Account holder's full name (print)	**Account holder signature** X

◯ CHARGE MY CREDIT/DEBIT CARD

By filling out this section, you are requesting that your premiums be automatically charged to your credit/debit card on the first day of each month, and agreeing to the terms outlined above.

Credit/Debit card information: ◯ **Credit** ◯ **Debit**	◯ **Visa** ◯ **MasterCard** ◯ **Discover** ◯ **American Express**
Cardholder's name as it appears on card	
Credit/Debit card number	**Expiration date (mm/yyyy)**
Cardholder signature X	**Date (mm/dd/yyyy)**

◯ I AM NOT INTERESTED IN THE AUTOMATIC PAYMENT OPTION

By selecting this option of not setting up automatic monthly payments, I will receive a monthly invoice from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Step 9: Enter Information for Your Agent, Broker, or Kaiser Permanente Representative (if you have one)

If you used a broker or a Kaiser Permanente for Individuals and Families (KPIF) representative, please make sure he or she completes this page. A KPIF representative includes any KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/Broker/KPIF representative (first, middle, last)

I (the applicant) authorize the insurance agent/broker/KPIF representative listed below to share enrollment, disenrollment, and summary plan information specific to this application with Kaiser Permanente. I understand that the agent/broker/KPIF representative listed on this application may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in connection with the purchase of this health plan coverage.

Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

Primary applicant or financially responsible party (parent or legal guardian for applicants under 18)			Date (mm/dd/yyyy)
X			
Kaiser Permanente–appointed broker identification number		**Broker license number/License state**	
228210944		1585616 / Maryland	
Broker firm name		**Broker firm federal tax ID number**	
Virginia Medical Plans		228210944	
Street address			**Suite**
1404 Northpoint Glen Court			
City		**State**	**ZIP**
Herndon		VA	20170
Phone	**Fax**	**Email address**	
(800) 867 – 0800	(888) 514 – 4258	jkatz@vamedicalplans.com	
General agent name		**General agent federal tax ID number**	