



Virginia Medical Plans

Application Instructions for Kaiser Permanente

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Kaiser Permanente** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submitting it to Kaiser for processing. This may reduce the underwriting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-867-0800 or 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.



Virginia Medical Plans

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Virginia Medical Plans

FAX# 888-514-4258

Dear Virginia Medical Plans,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Virginia Medical Plans at 800-867-0800 or 888-396-2341 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

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 Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente or Health Plan).

- 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 Virginia 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 the Health Insurance Marketplace in Virginia at healthcare.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 healthcare.gov, you should cancel that plan through healthcare.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: <input type="radio"/> Open enrollment (11/15/14 to 2/15/15) <input type="radio"/> A special enrollment period	If you selected "a special enrollment period," choose the triggering event: <input type="radio"/> Loss of health care coverage <input type="radio"/> Changes to federal financial assistance through healthcare.gov* <input type="radio"/> Permanent relocation or release from incarceration
	<input type="radio"/> Gaining or becoming a dependent (for example, through marriage or the birth of a child) <input type="radio"/> Employer health coverage changes Date of triggering event (mm/dd/yyyy): ____/____/____

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
<input type="radio"/> KP VA Bronze 4500/50/Dental/PedDental <input type="radio"/> KP VA Bronze 4500/50/HSA/Dental/PedDental <input type="radio"/> KP VA Bronze 5000/30%/HSA/Dental/PedDental	<input type="radio"/> KP VA Silver 1500/30/Dental/PedDental <input type="radio"/> KP VA Silver 2500/30/Dental/PedDental <input type="radio"/> KP VA Silver 1750/25%/HSA/Dental/PedDental	<input type="radio"/> KP VA Gold 0/20/Dental/PedDental <input type="radio"/> KP VA Gold 1000/20/Dental/PedDental	<input type="radio"/> KP VA Platinum 0/10/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, a certificate of exemption from the Health Insurance Marketplace in Virginia at **healthcare.gov** for each person that indicates lack of affordable coverage or financial hardship.

- KP VA 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.

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

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 <input type="radio"/> M <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No
City		State	ZIP	County
Main phone () -	Other phone () -	Preferred language spoken (if not English)		Preferred language read (if not English)

FOR ALL APPLICANTS 21 OR OLDER:

Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? Yes No
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Spouse

Name (first, middle, last)

Gender <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
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FOR ALL APPLICANTS 21 OR OLDER:

Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? Yes No
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

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 <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:

Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? Yes No
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Name (first, middle, last)			Relationship to primary applicant
Gender <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:

Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? Yes No
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Name (first, middle, last)			Relationship to primary applicant
Gender <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:

Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? Yes No
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Step 3: Enter Your Information (continued)

Dependents to Be Covered			
Name (first, middle, last)			Relationship to primary applicant
Gender <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
FOR ALL APPLICANTS 21 OR OLDER: Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? <input type="radio"/> Yes <input type="radio"/> No Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.			
Name (first, middle, last)			Relationship to primary applicant
Gender <input type="radio"/> M <input type="radio"/> F	Social Security number	Date of birth (mm/dd/yyyy)	Medical record number (if any)
FOR ALL APPLICANTS 21 OR OLDER: Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? <input type="radio"/> Yes <input type="radio"/> No Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.			

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 <input type="radio"/> M <input type="radio"/> F	Date of birth (mm/dd/yyyy)
Same address as primary applicant? <input type="radio"/> Yes <input type="radio"/> No If no, fill in your address below.		Relationship to applicant: <input type="radio"/> Parent/Legal guardian <input type="radio"/> Spouse <input type="radio"/> 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 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. Health Plan will refund any premiums paid back to the date of the denial or the effective date of the rescission of coverage less any medical costs incurred by Health Plan. 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 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: <input type="radio"/> Credit <input type="radio"/> Debit	<input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> Discover <input type="radio"/> 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: <input type="radio"/> Checking account <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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: <input type="radio"/> Checking account <input type="radio"/> Savings account	Bank name
Routing number	Account number
<small>(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.)</small>	
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: <input type="radio"/> Credit <input type="radio"/> Debit	<input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> Discover <input type="radio"/> 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)

Jonathan Katz

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) X		Date (mm/dd/yyyy)	
Kaiser Permanente-appointed broker identification number 228210944		Broker license number/License state 1585616 / Virginia	
Broker firm name Virginia Medical Plans		Broker firm federal tax ID number 228210944	
Street address 1404 Northpoint Glen Court			Suite
City Herndon		State VA	ZIP 20170
Phone (800) 867 - 0800	Fax (888) 514 - 4258	Email address jkatz@vamedicalplans.com	
General agent name		General agent federal tax ID number	