Kaiser Permanente Child Health Program

Instruction guide for completing the Kaiser Permanente for Individuals and Families Application for Health Coverage

This document provides instructions on how to complete the Kaiser Permanente for Individuals and Families (KPIF) Application for Health Coverage. Be sure to complete the KPIF application before you complete the Kaiser Permanente Subsidy Eligibility Form.

Many of the sections on the KPIF application do not apply to you. We have provided a screenshot of the KPIF application and we have shaded those areas that do not apply. For instance,

You **DO NOT** need to:

- Include any payment with your application.
- Provide a Social Security number. We are required to ask you for a Social Security number or tax identification number, but neither one is required for the Child Health Program.
- Complete any of the steps after Step 8.

You **DO** need to:

- Select the KP Platinum 90 health plan in Step 2.
- Photocopy the form if you are applying for more than 4 family members and include their information in Step 4.

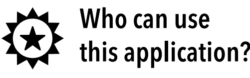
How to fill out the KPIF application

Screenshots of the KPIF application are included below, along with instructions for each step.

Please note, you do not need to complete any of the shaded sections as they do not apply to your application.

Application for health coverage

Individual and Family Plans



Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Permanente for Individuals and Families (KPIF).

- If you want coverage for your family on the same KPIF plan, please fill out 1 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 KPIF coverage, you must live in our California service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Covered California at coveredca.com.
- If you're already a member, don't use this form. To change your plan, call **1-866-410-7536.**

Things to remember

- You can apply faster online at **buykp.org/apply**.
- 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.
- 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're applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period guide and include any required documentation so your application will be complete. If you didn't receive this guide, you can find it at **buykp.org/apply**, or call **1-800-494-5314** to request a copy. Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- To avoid paying for 2 plans, if you are enrolled in another plan through Covered California or through Kaiser Permanente, you should end that plan before the start date of your new plan. To avoid a gap in coverage, be sure that plan ends the day before your new plan starts.
- **If your application is incomplete, not signed, doesn't include your first month's payment, or doesn't include required special enrollment period documentation, it may be canceled.**
- Send your complete, signed application and first month's premium payment by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-866-816-5139**

  Note: Checks must be mailed and can't be faxed.

Not applicable

Need help?

- For help with completing this application, please call **1-800-494-5314.** For TTY, call **711.**
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call him or her for assistance.

Not applicable

If you are applying outside of open enrollment, please see the Enrolling During a Special Enrollment Period guide in this packet, or visit **info.kp.org/childhealthprogram** to learn more about the requirements.

STEP 1: Tell us when you're applying

Select 1 option:

- ☐ Open enrollment
- ☐ A special enrollment period

If you're applying during a special enrollment period, please write the date of your triggering event.

Date (mm/dd/yyyy)

☐☐/☐☐/☐☐☐☐

For more information on minimum essential coverage and qualifying triggering events, please refer to the Enrolling During a Special Enrollment Period guide. To request a copy, please call **1-800-494-5314.**

If you selected "A special enrollment period," choose the triggering event:

- ☐ Loss of health care coverage*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership registration
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Release from incarceration
- ☐ Change in eligibility for federal financial assistance through Covered California†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Covered California
- ☐ Misinformation about coverage
- ☐ Provider network changes

Not applicable

*If your triggering event is loss of Kaiser Permanente coverage, we may review your prior membership records to establish eligibility.
†If you'll be getting federal financial assistance, don't use this form. We can help you apply at coveredca.com.

Check the box for the Kaiser Permanente – Platinum 90 HMO plan.

STEP 2: Choose your health plan

Choose 1 health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze	Silver	Gold	Platinum
☐ Kaiser Permanente – Bronze 60 HDHP HMO 5500/40%	☐ Kaiser Permanente – Silver 70 HMO	☐ Kaiser Permanente – Gold 80 HMO	☐ Kaiser Permanente – Platinum 90 HMO
☐ Kaiser Permanente – Bronze 60 HMO	☐ Kaiser Permanente – Silver 70 HMO 1750/40	☐ Kaiser Permanente – Gold 80 HMO Coinsurance	
☐ Kaiser Permanente – Bronze 60 HDHP HMO	☐ Kaiser Permanente – Silver 70 HDHP HMO 2700/15%		

Not applicable

Minimum coverage plan

To purchase a minimum coverage plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption from Covered California that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

- ☐ Kaiser Permanente – Minimum Coverage HMO

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement, Disclosure Form, and Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-634-4579,** or contact your broker.

STEP 3: Choose your optional dental plan

Not applicable

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental insurance plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. Please choose 1 option below.

- ☐ Yes, I agree to enroll in the KPIC dental insurance plan. Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the dental insurance plan. Once enrolled, you can't cancel your dental coverage without canceling your regular health coverage, unless you make the change during open enrollment or a special enrollment period.
- ☐ No. I'm not interested in optional dental coverage.

Any individual to be covered can be the primary applicant. If you have more than 1 family member to be covered, you can add them in the dependents section. If you have a Social Security number or a tax identification number, please include it. If you don't, please leave it blank.

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

Social Security number (if you have one)

Last name

Phone

MI

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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

City

State

ZIP code

County

Mailing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Spouse/domestic partner to be covered

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

First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

If there are more family members to be covered, add their information here. Do not repeat the primary applicant's information. If you are applying for more than 4 family members, photocopy this page, provide the information requested below, and submit it with this application.

STEP 4: Enter your information *(continued)*

Dependents to be covered If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

1 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Parent or legal guardian (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if you have one)

Gender:

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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.

First name

MI

Last name

Phone

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

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

Date (mm/dd/yyyy)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then his or her 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 signatures are missing, we will cancel the application.

- I understand that Kaiser Foundation Health Plan, Inc., will rely on the information provided in this application. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Foundation Health Plan, Inc., may choose to terminate coverage back to the coverage effective date.
- 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.

X

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

Date (mm/dd/yyyy)

X

Spouse/domestic partner

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

STEP 7: Sign the Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement, Disclosure Form, and Evidence of Coverage.*

X ______________________ Date (mm/dd/yyyy) __/__/____

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

X ______________________ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X ______________________ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X ______________________ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X ______________________ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

Stop – you do not have to complete Step 8 of the KPIF application to apply for CHP.

Please recycle. 60510125 November 2016