Community Health Care Program

Instructions for completing the Kaiser Permanente for Individuals and Families Application for Health Coverage

This document tells you how to complete the Kaiser Permanente for Individuals and Families (KPIF) Application for Health Coverage when applying for the Community Health Care Program (CHCP) in California.

What you need to do:

- **In Step 2,** select the Kaiser Permanente – Platinum 90 HMO health plan
- **In Step 4,** if you're applying for more than 3 dependents, follow the instructions
- **Sign and date** the application on pages 7 and 8.
- **Send your documents** in one of these ways:

  By email: CHC-Applications@kp.org

  By mail: Kaiser Permanente
  Attn: CHC
  P.O. Box 939095
  San Diego, CA 92193-9095

  By fax: **1-855-355-5334**

What you don't need to do:

Many sections of the KPIF application don't apply to you and you don't need to complete them. We've grayed out those sections in this guide so that you know what parts to skip.

- You don't need to include payment with your application.
- You don't need to provide a Social Security number. We're required to ask you for a Social Security number or tax identification number, but neither one is required.
- You don't need to complete any steps after Step 7 in the KPIF application. No payment information is required.

We're here to help

If you have any questions, please call Member Services at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (closed major holidays).

KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use 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 California 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 **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- Please note the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to California residents free of charge. Call HICAP at 1-800-434-0222 to learn more. See page 12 to find your local HICAP program information.
- If you qualify for and want federal or state 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.
- To make changes to your existing KPIF account, call **1-800-464-4000** (TTY **711**).

Things to remember

- If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 31. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for instructions.
- 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.
- 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.
- **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, first month's payment, 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: **1-866-816-5139**

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

Need help?

- For help with completing this application, please call **1-800-494-5314** (TTY **711**).
- **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, Inc., One Kaiser Plaza, Oakland, CA 94612.

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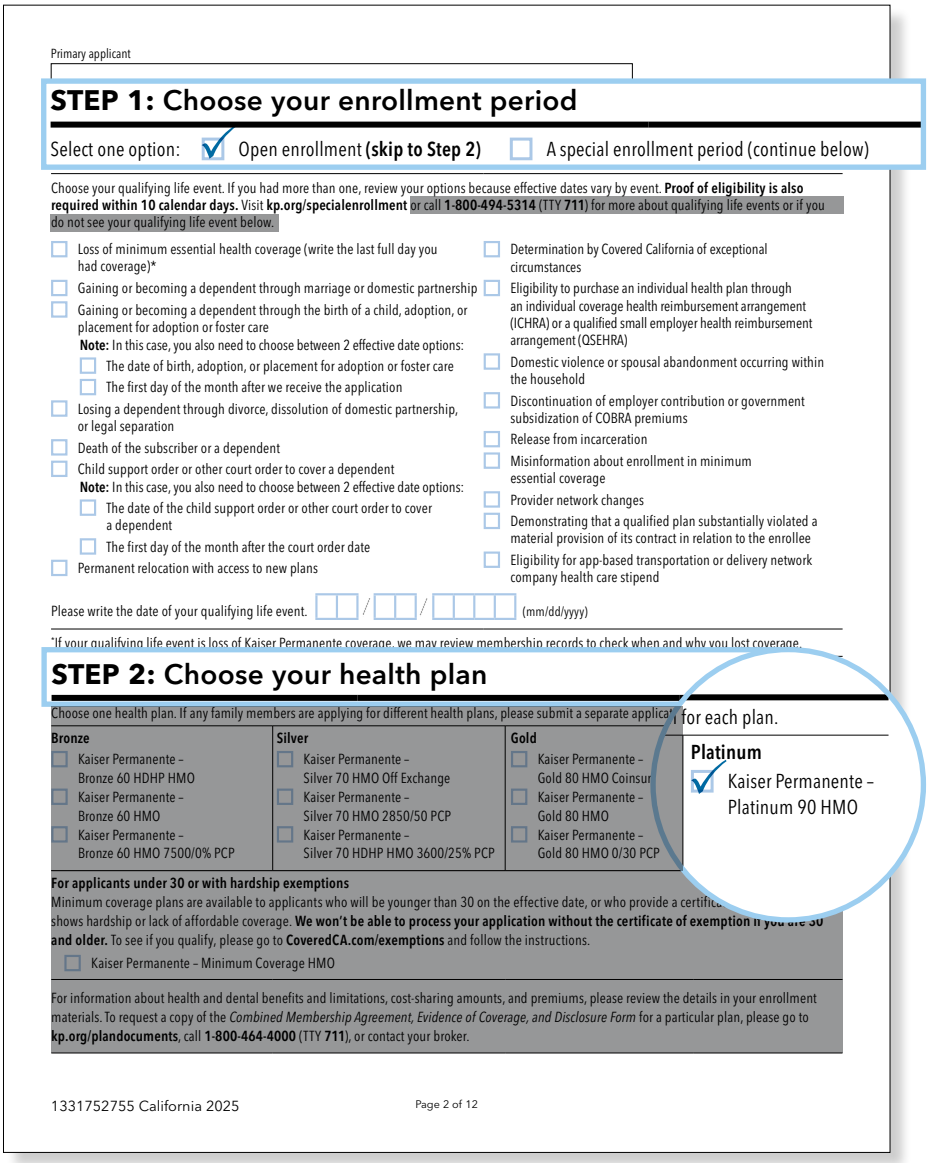
When you fill out your Application for Health Coverage, follow the instructions and examples below.

For help, call **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (closed major holidays).

- The grayed-out sections don't apply to you.
- You don't need to include payment with your application.



Primary applicant

STEP 1: Choose your enrollment period

Select one option: ☑ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  - **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after we receive the application
- ☐ 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
  - **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Determination by Covered California of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums
- ☐ Release from incarceration
- ☐ Misinformation about enrollment in minimum essential coverage
- ☐ Provider network changes
- ☐ Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee
- ☐ Eligibility for app-based transportation or delivery network company health care stipend

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.

STEP 2: Choose your health plan

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

Bronze	Silver	Gold	Platinum
☐ Kaiser Permanente – Bronze 60 HDHP HMO	☐ Kaiser Permanente – Silver 70 HMO Off Exchange	☐ Kaiser Permanente – Gold 80 HMO Coinsur	☑ Kaiser Permanente – Platinum 90 HMO
☐ Kaiser Permanente – Bronze 60 HMO	☐ Kaiser Permanente – Silver 70 HMO 2850/50 PCP	☐ Kaiser Permanente – Gold 80 HMO	
☐ Kaiser Permanente – Bronze 60 HMO 7500/0% PCP	☐ Kaiser Permanente – Silver 70 HDHP HMO 3600/25% PCP	☐ Kaiser Permanente – Gold 80 HMO 0/30 PCP	

For applicants under 30 or with hardship exemptions

Minimum coverage plans are available to applicants who will be younger than 30 on the effective date, or who provide a certific 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 **CoveredCA.com/exemptions** 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 *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-464-4000** (TTY **711**), or contact your broker.

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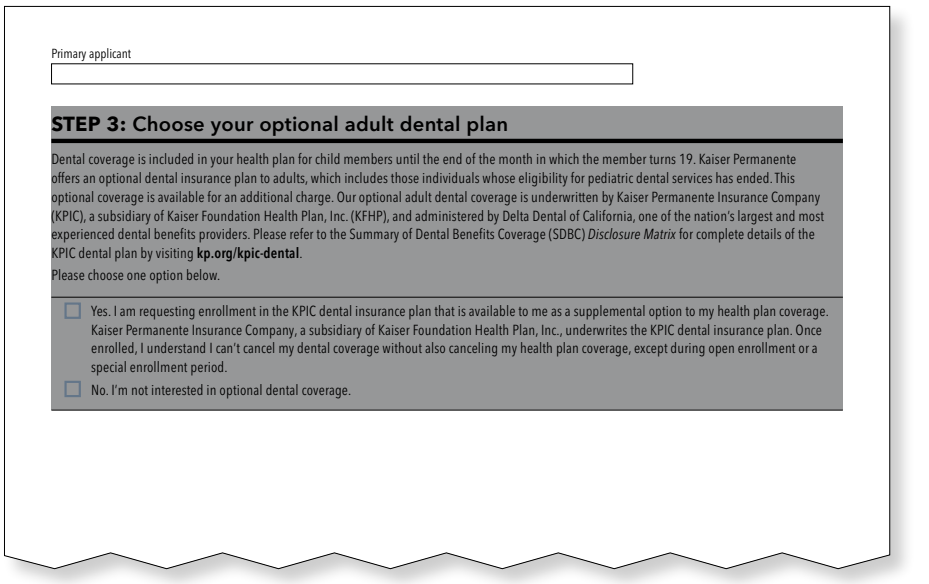

Primary applicant

STEP 3: Choose your optional adult dental plan

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 refer to the Summary of Dental Benefits Coverage (SDBC) *Disclosure Matrix* for complete details of the KPIC dental plan by visiting **kp.org/kpic-dental**.

Please choose one option below.

- ☐ Yes. I am requesting enrollment in the KPIC dental insurance plan that is available to me as a supplemental option to my health plan coverage. Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the KPIC dental insurance plan. Once enrolled, I understand I can't cancel my dental coverage without also canceling my health plan coverage, except during open enrollment or a special enrollment period.
- ☐ No. I'm not interested in optional dental coverage.

If you're applying outside of open enrollment, please see the Special Enrollment Period Guide or visit kp.org/chcspecialenrollment to learn more about the requirements.

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

⃠ The grayed-out sections don't apply to you.

⃠ The Community Health Care Program doesn't include an adult dental plan option.

Primary applicant

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 | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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

City

State | ZIP code | County | Phone (mobile phone if available)

Mailing address ☐ Check if same as home address

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

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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Fill in information about the primary applicant. A Social Security number can be included here, but it's not required.

⃠ You don't need to provide a Social Security number. We're required to ask you for a Social Security number or tax identification number, but neither one is required.

Primary applicant

Parent or legal guardian

Please complete this section if the primary applicant is a child under 18. The parent or legal guardian must be 18 or older.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

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 the state of California.

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

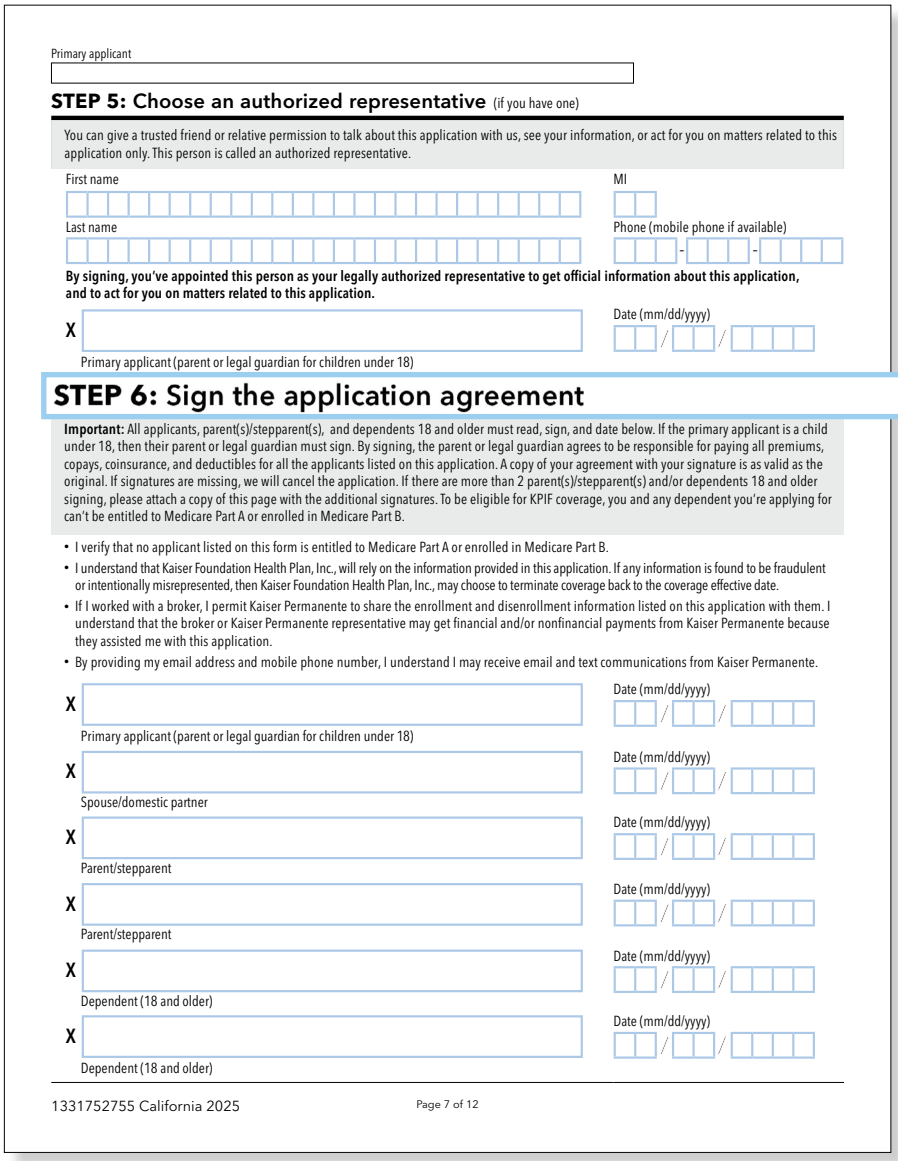
Last name

Date of birth (mm/dd/yyyy)

If there are more family members to be covered, add their information on page 5 of the application.

If you're applying for more than 3 dependents, photocopy page 5, and submit it with this application.

⃠ Don't repeat the primary applicant's information.



Primary applicant

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 only. This person is called an authorized representative.

First name | MI

Last name | Phone (mobile phone if available)

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, parent(s)/stepparent(s), and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then their 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. If there are more than 2 parent(s)/stepparent(s) and/or dependents 18 and older signing, please attach a copy of this page with the additional signatures. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- 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.
- If I worked with a broker, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the broker or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

X Primary applicant (parent or legal guardian for children under 18) Date (mm/dd/yyyy)

X Spouse/domestic partner Date (mm/dd/yyyy)

X Parent/stepparent Date (mm/dd/yyyy)

X Parent/stepparent Date (mm/dd/yyyy)

X Dependent (18 and older) Date (mm/dd/yyyy)

X Dependent (18 and older) Date (mm/dd/yyyy)

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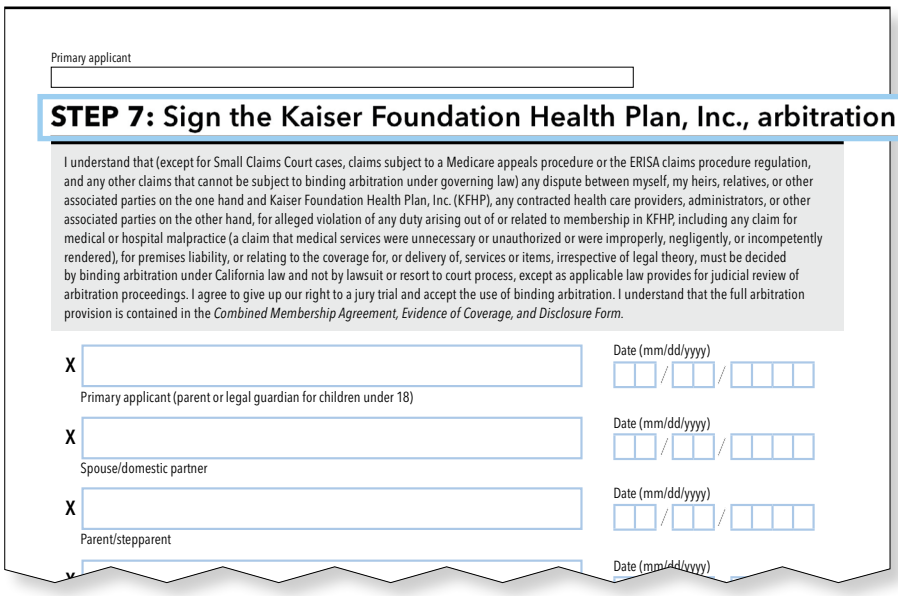
Sign if you'd like to appoint an authorized representative like a trusted friend or an enrollment assister.

Sign and date the application agreement.

You won't pay monthly premiums, and you'll have low or no costs for most covered services at Kaiser Permanente facilities when you're a CHCP member.



Primary applicant

STEP 7: Sign the Kaiser Foundation Health Plan, Inc., 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 *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form.*

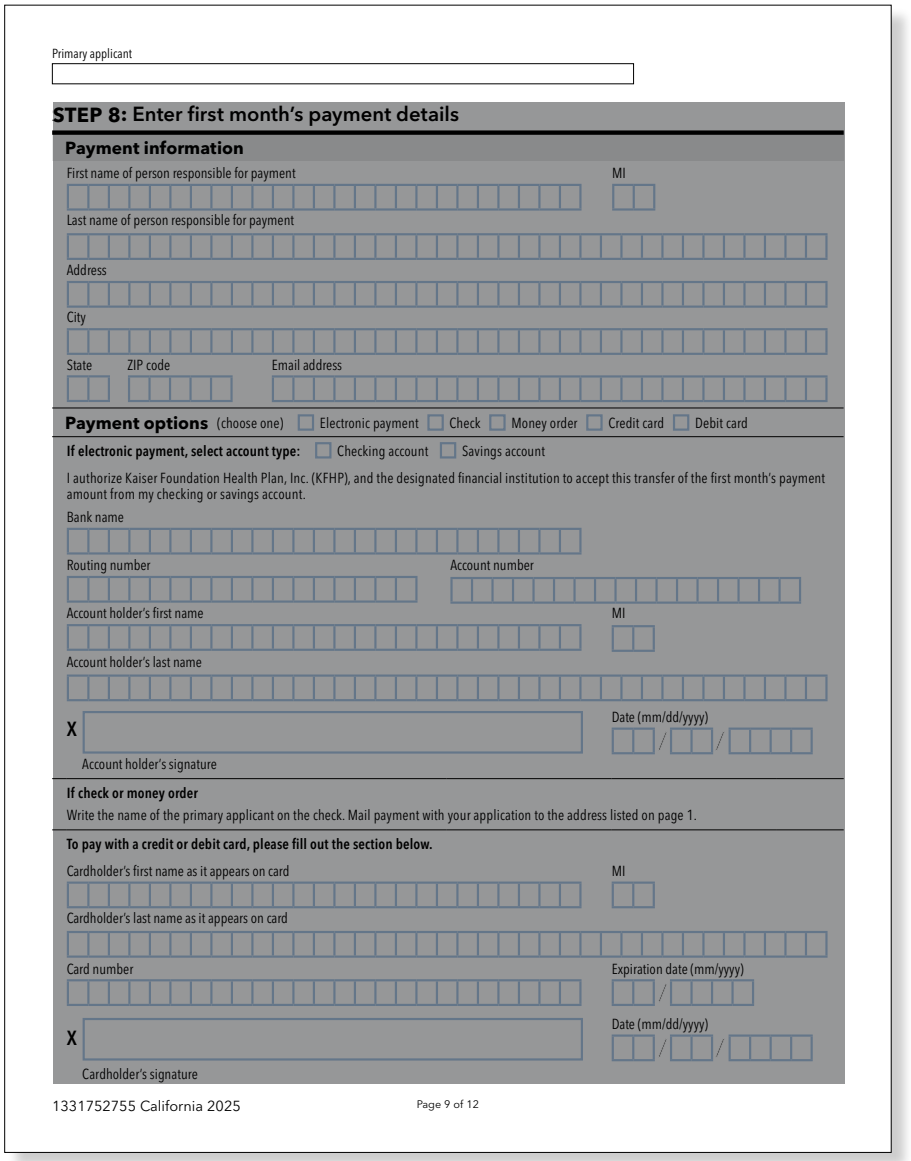
X Primary applicant (parent or legal guardian for children under 18) Date (mm/dd/yyyy)

X Spouse/domestic partner Date (mm/dd/yyyy)

X Parent/stepparent Date (mm/dd/yyyy)

X Date (mm/dd/yyyy)

Sign and date the arbitration agreement.



Primary applicant

STEP 8: Enter first month's payment details

Payment information

First name of person responsible for payment — MI

Last name of person responsible for payment

Address

City

State — ZIP code — Email address

Payment options (choose one) ☐ Electronic payment ☐ Check ☐ Money order ☐ Credit card ☐ Debit card

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 of the first month's payment amount from my checking or savings account.

Bank name

Routing number — Account number

Account holder's first name — MI

Account holder's last name

X Account holder's signature — Date (mm/dd/yyyy)

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address 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 Cardholder's signature — Date (mm/dd/yyyy)

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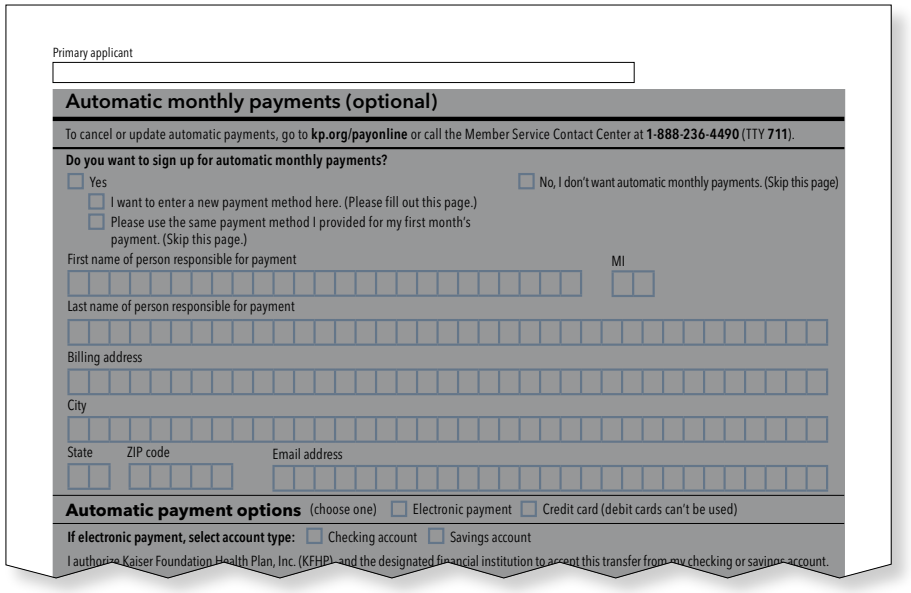


Primary applicant

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-888-236-4490** (TTY **711**).

Do you want to sign up for automatic monthly payments?

☐ Yes ☐ No, I don't want automatic monthly payments. (Skip this page)

☐ I want to enter a new payment method here. (Please fill out this page.)

☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)

First name of person responsible for payment — MI

Last name of person responsible for payment

Billing address

City

State — ZIP code — Email address

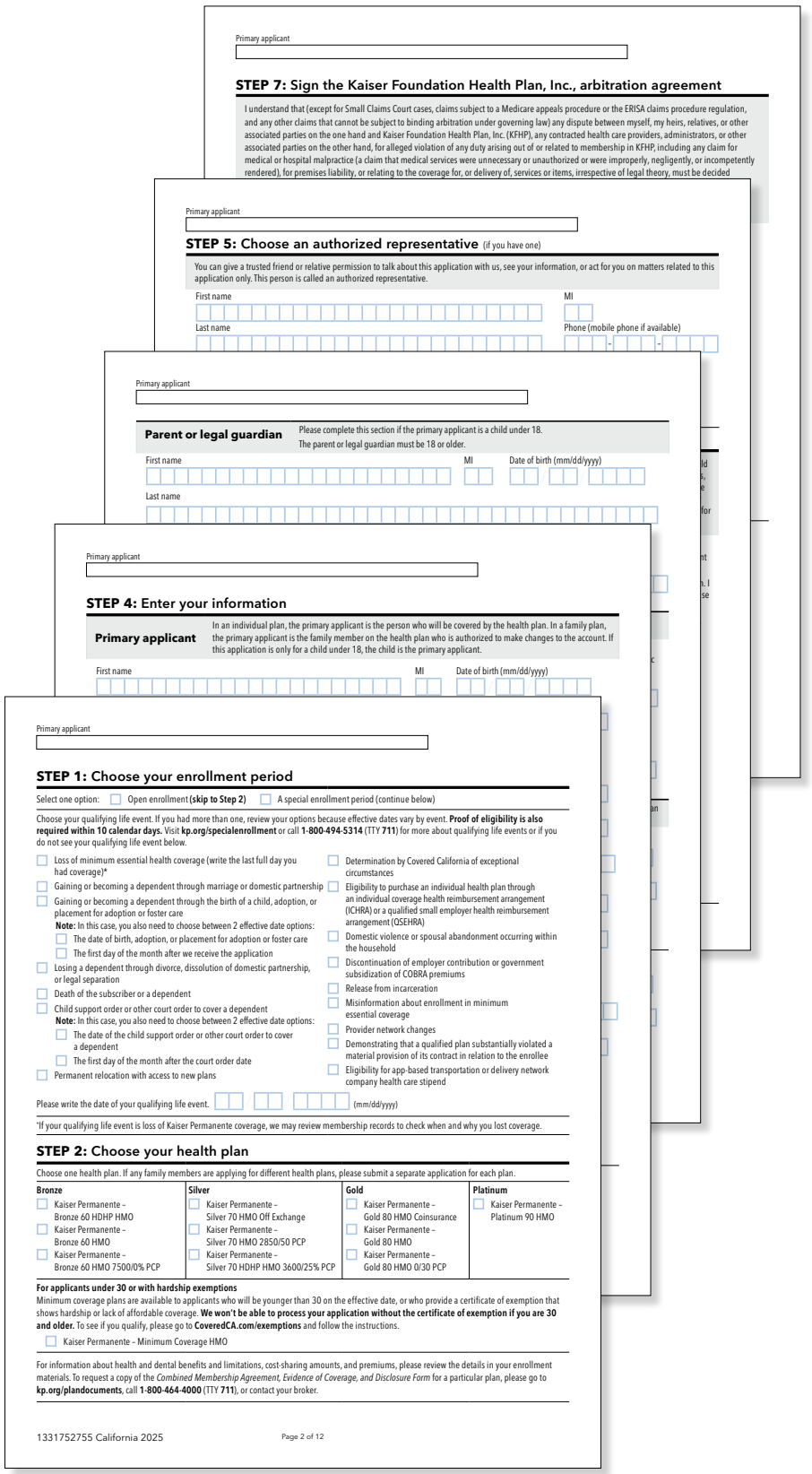
Automatic payment options (choose one) ☐ Electronic payment ☐ Credit card (debit cards can't be used)

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.

You don't need to complete any steps after Step 7 in the KPIF application.

⃠ You don't need to include payment with your application.



Primary applicant

STEP 7: Sign the Kaiser Foundation Health Plan, Inc., 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

Primary applicant

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 only. This person is called an authorized representative.

First name MI

Last name Phone (mobile phone if available)

Primary applicant

Parent or legal guardian Please complete this section if the primary applicant is a child under 18. The parent or legal guardian must be 18 or older.

First name MI Date of birth (mm/dd/yyyy)

Last name

Primary applicant

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 MI Date of birth (mm/dd/yyyy)

Primary applicant

STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
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☐ Kaiser Permanente – Minimum Coverage HMO

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P.O. Box 23127
San Diego, CA 92193-3127

Fax
1-855-355-5334

We're here to help

If you have any questions, please call Member Services at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (closed major holidays).

Notes