

**Kaiser Foundation Health Plan of the Northwest
Individuals and Families**
Section 1 – Instructions

- **Do not include the first month's payment. If you are accepted, we will send you a bill.**
- Please use a **pen** to complete and sign this application.
- Make sure this application is **complete** and **signed**. Parents or legal guardians must sign for children under the age of 18. Applicants who are 15 years of age and older must sign the *Authorization to Obtain or Release Medical Information*. We are unable to process applications without appropriate signatures.
- If you have general questions regarding Individuals and Families or questions regarding this application form, please call **1-800-914-5521**. To be eligible for this plan, you must live in our Southwest Washington service area.
- **If this application contains any material misstatements or omissions, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

Section 2 – Plan selection and rate information
Choose one Individuals and Families Plan:

- | | |
|--|--|
| <input type="checkbox"/> Silver \$500 Plan with Rx | <input type="checkbox"/> Silver \$4,000 Plan |
| <input type="checkbox"/> Silver \$1,000 Plan with Rx | <input type="checkbox"/> Silver \$6,000 Plan |
| <input type="checkbox"/> Silver \$2,500 Plan with Rx | |

Tobacco use information

The smoker rate will apply if any family members listed on this application have used tobacco products within the 12 months prior to this application. **Have you or any family members listed on this application used tobacco products in any form during the past 12 months?** **Yes** **No** If Yes, list the name(s) of the individual(s): _____

I would like to begin coverage on: the next available effective date the 1st day of _____
(cannot be more than **60 days** from date application signed)

I am adding a new person to an existing Individuals and Families account.

Subscriber's health record number:

Note: Your plan options may be limited based on review of your application and medical history.

Section 3 – Enrollment information

Complete the following information **and** submit one application for **each** family member **applying**:

Applicant	Last name	First name	Middle initial	Previous name(s)	Marital status
Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Social Security number	Health record number

Names of other family members submitting applications. (This helps us to process family members together.)

Spouse	Last name	First name	Middle initial	Date of birth	Previous name(s)
Child					
Child					
Child					

Household information

Address	City	State	ZIP
Home phone	Work phone		

For official use only

Date received:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> New account | <input type="checkbox"/> Reapplication | Effective date: _____ |
| <input type="checkbox"/> Conversion | <input type="checkbox"/> Upgrade | <input type="checkbox"/> Approved <input type="checkbox"/> Denied |
| <input type="checkbox"/> Add-on | | |

Section 4 – Prior or current coverage

This coverage has a nine-month waiting period for pre-existing conditions. This means that we do not pay for expenses incurred by you or your enrolled dependent(s) for pre-existing conditions during the nine months following your or your enrolled dependent's effective date of coverage. A *pre-existing condition* is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

The pre-existing condition exclusion is waived (1) if you are currently a member and adding a newborn or new adoptee, or (2) if you are applying for new coverage and had prior insurance coverage.

If you are not a HIPAA-eligible individual and had or have had group or individual coverage within 63 days of the date of this application, that coverage may reduce the nine-month pre-existing condition exclusion. Please read the section below describing the conditions you must satisfy in order for your prior coverage to reduce the pre-existing condition exclusion, and check the appropriate box.

Pre-existing condition waiting period waiver

- I am a HIPAA-eligible individual.** If you are applying for individual coverage, we will waive the nine-month pre-existing condition waiting period for you and/or your enrolled dependent(s) if you and/or your enrolled dependent(s) qualify as HIPAA-eligible.

Crediting prior coverage to reduce the pre-existing condition exclusion

- I have or have had group or individual coverage within 63 days of the application date.** Under certain circumstances, we will reduce the duration of the pre-existing exclusion by the coverage you or your enrolled dependent had within 63 days of the date you or your dependent applied for coverage. Prior creditable coverage is determined separately for each enrollee.

If crediting prior coverage to reduce the pre-existing condition exclusion applies to you and your dependent(s), fill in the appropriate blanks at the end of this section and provide appropriate documentation. If necessary, we may request a copy of your certificate of creditable coverage.

The following information can be used to prove prior coverage:

1. Pay stubs that reflect a premium deduction
2. Explanation of benefits forms
3. A benefit termination notice from Medicare or Medicaid
4. Verification by a doctor or your former health care benefits provider that you had prior health coverage
5. Certificate of creditable coverage

Details regarding current or prior coverage

1. Name of insurance company _____
Phone (_____) _____
2. Date coverage began _____
Date coverage ended _____
3. Type of coverage:
 - Group plan
 - Church plan
 - Individual plan
 - Washington Basic Health Plan (BHP)
 - WSHIP
 - Healthy options plan
 - Federal plan
(e.g., TRICARE, FEBHP, or Peace Corps Act)
 - Plan established/maintained by a foreign country or any political subdivision thereof
 - PEBB or Uniform Medical Plan
 - Plan of Indian Health Service or tribal organization
 - College, school, or short-term insurance
4. Deductible amount per year:
 - Individual _____
 - Family _____
5. Coinsurance _____
6. Coverage does or did include:
 - Maternity
 - Hospital only
 - Prescription drug
 - Waiting periods for organ transplants
 - None of the above
7. Names of individuals covered by current or prior insurer

8. Are you currently on or did you recently exhaust COBRA or state continuation coverage?
 - Yes
 - No
 If Yes, date coverage began _____
Date coverage ended _____
9. Are you eligible for the following?
 - Medicare Part A or B Yes No
 - Medicaid Yes No

Section 5 – Standard Health Questionnaire requirements

A separate *Standard Health Questionnaire* must be submitted for each person listed on this application. (See the *Standard Health Questionnaire* for specific guidelines.) **If you or your family members are exempt from completing the questionnaire, please check the reason below and mail documentation along with the completed application to Individuals and Families, P.O. Box 7104, Pasadena, CA 91109-9835.**

- I am adding a newborn/newly-placed-for-adoption child** to my current plan within 60 days of such event.

Provide the following documentation along with your application:

1. Copy of birth certificate
or
2. Adoption placement paper
or
3. Confirmation letter of legal obligation

- I/we exhausted COBRA.** This application is being submitted within 90 days of the date COBRA coverage ended or will be ending.

Provide the following documentation along with your application:

1. Certificate of creditable coverage
or
2. Letter from your employer noting beginning/ending dates of COBRA plan

- I/we moved** from one part of Washington state to another within the last 90 days, and the insurance carrier we had does not offer coverage in my new location.

Provide the following documentation along with your application:

1. Copy of your most recent utility bill from your previous residence and your new residence
and
2. Certificate of creditable coverage

- My/our health care provider** (from whom I/we received treatment within the last 12 months) left the network of my/our current individual plan within the last 90 days and is a part of the Kaiser Foundation Health Plan of the Northwest (KFHPNW) network of the plan for which I'm applying.

Provide the following documentation along with your application:

1. Letter from the provider
or
2. Certificate of creditable coverage

- My/our prior or current coverage has been through an employer** with fewer than 20 employees, and, due to federal regulations, the employer did not provide COBRA benefits. I have had 24 continuous months of group health coverage immediately prior to a qualifying event and am applying within 90 days prior to or after a qualifying event. A *qualifying event* is one of the following: death of a covered employee; termination of employment or reduction of work hours of the covered employee; divorce or legal separation of the covered employee from his/her spouse; covered employee becoming entitled to Medicare benefits; dependent child no longer eligible for coverage under the employee/parent's health coverage; and, with respect only to retirees and their dependents, bankruptcy of the employer sponsoring the plan.

Provide the following documentation along with your application:

1. Certificate of creditable coverage
and
2. A letter from your employer noting beginning/ending dates of coverage, number of employees, and persons covered on plan

- My/Our prior or current coverage has been through** Washington Basic Health Plan (BHP) and I/we have had 24 months of continuous coverage under the plan immediately prior to disenrollment. I/we am/are applying for individual coverage no more than 90 days prior to when I/we will lose the BHP coverage or within 90 days after it is lost.

Provide the following documentation along with your application:

1. Certificate of creditable coverage

Section 6 – Standard Health Questionnaire instructions

General description

The health questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is for people who are unable to obtain individual medical coverage with insurance carriers.

By completing this form, you will be giving your medical information to Kaiser Foundation Health Plan of the Northwest (KFHPNW). Your answers will determine if KFHPNW will accept your application or if you will be referred to WSHIP.

This health questionnaire is not for people who have Medicare benefits.

When evaluating your application, KFHPNW will not consider any medical information except what you provide on this form. Your answers will be scored using a standard scoring system designed by WSHIP. KFHPNW does not have control over the questions or the scoring system.

If you are rejected for coverage and request an appeal, KFHPNW may then request further information. You may choose to supply this added information if you believe it will be of assistance in scoring your questionnaire correctly.

A copy of the scoring system document is available by calling the WSHIP administrator at **1-800-877-5187**. Documents may be viewed and printed by going to the WSHIP Web site at <http://www.wship.org>. **Questions about the scoring of your questionnaire should be directed to KFHPNW or your insurance agent/producer, but not to the WSHIP administrator.**

KFHPNW may not reject your application unless we mail a notice of rejection within 15 business days after we have received your completed submission. **To be complete, this health questionnaire must be signed and dated with no missing information that might affect your score, and the application must be completed in its entirety.**

Instructions

1. This application, including the health questionnaire, must be filled out completely and submitted to Individuals and Families, P.O. Box 7104, Pasadena, CA 91109-9835.
2. This health questionnaire must be completed in full and will be valid for a 90-day period. If you wait more than 90 days to submit your application, you will have to complete a new health questionnaire.
3. Any time you apply for individual coverage or change from one carrier to another, a new health questionnaire will be required.
4. Do not send medical records with this questionnaire. KFHPNW does not require medical records to process your application.
5. If you are applying for family coverage, a separate questionnaire must be completed for each family member.
6. Make sure that you **sign and date** this application and mail it to KFHPNW along with any other required materials.
7. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
8. If you have questions about this form, contact your insurance agent/producer or call KFHPNW at **1-800-914-5521**.

Section 7 – Certification/Authorization

Certification of completion and correctness

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form. **I understand that if this application contains any material misstatements or omissions, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may deny coverage; modify, cancel, terminate, or rescind the contract; and/or take any other legal action available to it by law.** I will promptly inform KFHPNW in writing if anything happens before my coverage takes effect that makes the application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by KFHPNW. If approved, coverage will be in force as of the effective date determined by KFHPNW. KFHPNW may contact me by phone to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my 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 include imprisonment, fines, and denial of insurance benefits.

X

Applicant's signature

If you are signing on behalf of an underage child, check: Parent Legal guardian

Agent/Producer authorization

(if you are working with a health insurance agent/producer)

I (the member) authorize the insurance agent/producer listed below to share enrollment, disenrollment, and summary plan information specific to this application with the insurance carrier. I understand that the agent/producer of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Northwest (KFHPNW) in connection with the purchase of this health plan coverage.

X

Applicant's signature

I (the agent/producer) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written materials furnished by KFHPNW. The applicant has been informed that the effective date of coverage is assigned by KFHPNW. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agency name

Agency number

Agent/Producer name

X

Agent/Producer signature

If you do not sign this questionnaire, it will be returned to you and your application process will be delayed.

Individuals and Families authorization

Authorization to obtain or release Medical Information

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional who has provided any services to an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product) to give Kaiser Foundation Health Plan of the Northwest (KFHPNW) or its affiliates, its respective agents, employees, designees, or representatives, including my insurance agent or broker, any Applicant's *Medical Information* (defined as **any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, sexually transmitted diseases, HIV [human immunodeficiency virus] status, AIDS [acquired immune deficiency syndrome], or ARC [AIDS-related complex]**). However, Medical Information does not include genetic information or *psychotherapy notes* (as defined by 45 C.F.R. § 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize KFHPNW to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize KFHPNW to disclose to my insurance agent or producer the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the coverage.

I will sign new authorizations, if necessary, so that in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits, KFHPNW may request, use, and disclose Medical Information, HIV/AIDS- or ARC-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by KFHPNW in connection with the review, investigation, or evaluation of any claim for benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy of this authorization is as valid as the original, and I and my insurance agent or broker are entitled to receive a copy of this form.

I may revoke this authorization (to the extent applicable to my Medical Information) at any time prior to its expiration. However, revocation is not effective to the extent that KFHPNW has already taken action in reliance on it, or for so long as KFHPNW may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations are in KFHPNW's *Notice of Privacy Practices*.

X Primary applicant/Parent or legal guardian (age 18 or over)	Today's date	Date of birth
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X Applicant's spouse	Today's date	Date of birth
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X Applicant (age 15 or over)	Today's date	Date of birth
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Signatures (required)

Important: Required signatures all **Applicants age 18 or over must sign and date** above on the appropriate signature line (Primary applicant/Parent or legal guardian, Applicant's spouse). A parent or legal guardian must sign for dependents under the age of 18. In addition, all **Applicants age 15 or over must sign and date** above on the designated signature line.

Use black ink only.

**Please read and sign in all the places noted and photocopy for your records.
We will be unable to process your application without your signature.**