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 Foundation Health Plan of the Northwest (KFHPNW) plan.

- If you want coverage for your family on the same KFHPNW plan, please fill out one application for the family. If someone in your family wants a different health or dental plan, they must complete a separate application.
- To be eligible for KFHPNW coverage, you must live in our Southwest Washington 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 KFHPNW coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Washington Healthplanfinder at **wahealthplanfinder.org**.
- If you're already a KFHPNW member, don't use this form. To make changes to your account, call **1-800-813-2000.**

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 15.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** for instructions.
- Please send this application back as quickly as you can – or 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.
- Remember, if you're enrolling in a new plan, that 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 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: **1-855-355-5334**

  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 producer, please call them for assistance.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232.

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 calendar 10 days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events.

☐ Loss of minimum essential health coverage (write the last full day you had coverage)*

Did you lose coverage with us (KFHPNW) that was provided by your employer?

☐ Yes ☐ No

If Yes, you have 2 options for continuing your coverage with us

- ☐ Coverage that begins automatically the day after your employer coverage ends
- ☐ Coverage that begins based on when we receive your application. Please see **kp.org/specialenrollment** under "Loss of minimum essential health coverage" for more details

☐ 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 the birth or placement of the child with you

☐ 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 Washington Healthplanfinder 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 to COBRA premium

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

*If your qualifying life event is loss of KFHPNW 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 application for each plan.

Bronze	Silver	Gold
☐ KP WA Bronze 8900/75 with Pediatric Dental	☐ KP WA Silver 4500/50 with Pediatric Dental	☐ KP WA Gold 2000/20 with Pediatric Dental
☐ KP WA Bronze 6900/0% HSA with Pediatric Dental	☐ KP WA Silver 3000/35% HSA with Pediatric Dental	☐ KP WA Gold 0/20 with Pediatric Dental
☐ KP WA Bronze 6000/50 with Pediatric Dental	☐ KP WA Silver 750/30 with Pediatric Dental	

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 *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-813-2000,** or contact your producer.

STEP 3: Choose your optional adult dental plan

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 for an additional monthly charge.

☐ Yes, I'd like to enroll in a dental plan. ☐ No, I'm not interested in dental coverage.	If Yes, please select your dental plan.	☐ KP WA Dental 100 ☐ KP WA Dental 80

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 health 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)

Billing address (if different than home address)

City

State | ZIP code

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

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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)

Primary applicant

Spouse/domestic partner to be covered

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

First name

MI

Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Former health record number (if any) — State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former health record number (if any) — State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

2 First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former health record number (if any) — State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Primary applicant

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

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

Last name

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

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 _____ Date (mm/dd/yyyy)

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

STEP 6: Sign the application agreement

Important: The primary applicant 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 your signature is missing, we will cancel the application. To be eligible for KFHPNW 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.
- If I worked with a producer, I permit KFHPNW to share the enrollment and disenrollment information listed on this application with them. I understand that the producer or Kaiser Permanente representative may get financial and/or nonfinancial payments from KFHPNW because they assisted me with this application.
- 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. I acknowledge by my signature that the information I have supplied on this form is true and correct.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

X _____ Date (mm/dd/yyyy)

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

Primary applicant

STEP 7: 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

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 when my application is processed by KFHP.

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) / /

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 **1-866-291-4010.**

Do you want to sign up for automatic monthly payments?

☐ Yes

- ☐ 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.)

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

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

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.

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)

To pay with a credit 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)

Primary applicant

For applicants using a producer or Kaiser Permanente representative

If a producer or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The producer may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Our standard compensation is $18 for medical plans and $2.50 for dental plans, per member per month, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

Note: Premiums are the same whether or not you use a producer or Kaiser Permanente representative.

To be completed by your producer or representative after you complete this application:

Agency name

Agency ID number

Producer or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone (mobile phone if available)

Fax

Email address

I (the producer or Kaiser Permanente representative) haven't misrepresented any provisions, benefits, conditions, or limitations of the *Evidence of Coverage* from written materials provided by KFHPNW. I have informed the applicant that the effective date of coverage is assigned based on when KFHPNW receives their application. I certify that I have accurately and truthfully communicated the information given to me by the applicant on this application.

☐ Yes ☐ No

X

Producer or Kaiser Permanente representative

Date (mm/dd/yyyy)

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, Phone: 1-800-368-1019, TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

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