KAISER PERMANENTE®

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 Foundation Health Plan of Georgia, Inc. (KFHPGA).

- If you want coverage for your family on the same KFHPGA 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 KFHPGA coverage, you must live in our Georgia service area.
- To be eligible for KFHPGA coverage, you can't be entitled to Medicare Part A or enrolled in Medicare Part B.
- 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 the Health Insurance Marketplace at healthcare.gov.
- 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, you can find instructions at **kp.org/specialenrollment** or call **1-800-494-5314.** Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- Remember, this new enrollment will not end other coverage through the Health Insurance Marketplace or Kaiser Permanente. Don't want 2 plans? Be sure to end your other plan the day before your new plan starts to avoid paying 2 premiums or having a gap in your coverage.
- **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: **1-866-920-6476**

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

Need help?

- For help with completing this application, please call **1-800-914-5521.** 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.

All plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc.,
Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305.

Primary applicant

STEP 1: Check your eligibility

Are you or anyone else in your family either entitled to Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No

If you selected "Yes," those of you who are entitled to Medicare Part A or enrolled in Medicare Part B can't enroll in an individual and family plan. Please visit **kp.org/medicare** to learn more about your Medicare plan options or apply for coverage.

STEP 2: 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 (or qualifying life event).

Date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

For more information on minimum essential coverage and qualifying triggering events, please visit **kp.org/specialenrollment** or call **1-800-494-5314.**

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

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Child support order or other court order to cover a child
- ☐ Permanent relocation
- ☐ Change in eligibility for federal financial assistance through the Health Insurance Marketplace†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by the Health Insurance Marketplace

*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 healthcare.gov.

STEP 3: 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

- ☐ KP GA Bronze 5000/50
  KP GA Signature Bronze 5000/50‡
- ☐ KP GA Bronze 6200/40%/HSA
  KP GA Signature Bronze 6200/40%/HSA‡

Silver

- ☐ KP GA Silver 3000/30
  KP GA Signature Silver 3000/30‡
- ☐ KP GA Silver 2750/20%/HSA
  KP GA Signature Silver 2750/20%/HSA‡
- ☐ KP GA Silver Std 3500/30
  KP GA Signature Silver Std 3500/30‡
- ☐ KP GA Silver 4700/35
  KP GA Signature Silver 4700/35‡

Gold

- ☐ KP GA Gold 500/20
  KP GA Signature Gold 500/20‡
- ☐ KP GA Gold 1500/20
  KP GA Signature Gold 1500/20‡

Catastrophic plan

We also offer a Catastrophic plan, a high-deductible option for applicants under 30 and certain people 30 and older. If you or any family members are 30 or older, you may apply for this plan only if you submit with your completed application a certificate of exemption from the Health Insurance Marketplace that indicates lack of affordable coverage or financial hardship. A certificate of exemption is required for each applicant 30 or older.

- ☐ KP GA Catastrophic 7350/0/KP GA Signature Catastrophic 7350/0‡

‡If you live in Clayton, Cobb, Dekalb, Fulton, Gwinnett, or Henry County, your plan will be in the KP Signature HMO network. Please see the *KPIF Enrollment Guide* for important information on plans with the KP Signature HMO network.

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 **1-800-634-4579,** or contact your broker.

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 any)

Last name

Date of birth (mm/dd/yyyy)

MI

Former health record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Phone

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

City

State

ZIP code

County

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

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 (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if any)

(continues)

STEP 4: Enter your information *(continued)*

Spouse/domestic partner to be covered

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

First name

MI

Choose one: ☐ Spouse ☐ Domestic partner

Last name

Social Security number (if any)

Former health record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? ☐ Yes ☐ No

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

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

Last name

Social Security number (if any)

Former health record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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)? ☐ Yes ☐ No

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

2 First name

MI

Last name

Social Security number (if any)

Former health record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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)? ☐ Yes ☐ No

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

3 First name

MI

Last name

Social Security number (if any)

Former health record number (if any)

State (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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)? ☐ Yes ☐ No

Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums.

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

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: 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 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.

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)

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

☐ **Credit card** ☐ **Debit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

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)

☐ **Electronic payment** ☐ 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 premium 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)

☐ **Check** ☐ **Money order**

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

Primary applicant

Automatic monthly payments

This **optional** service allows you to automatically pay your monthly premiums electronically on the last day of the month (unless it falls on a weekend or holiday). If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-866-278-9502.**

Billing information

Is this information the same as your first month's payment details? ☐ Yes ☐ No **If no, please fill out this section.**

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State ZIP code

Payment options

Debit cards can't be used for automatic monthly payments.

☐ **Credit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

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

Date (mm/dd/yyyy)

/ /

Cardholder's signature

☐ **Electronic payment** ☐ 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

Date (mm/dd/yyyy)

/ /

Account holder's signature

Primary applicant

STEP 8: Enter information for your agent/broker/KPIF representative (if you have one)

I (the applicant) authorize the agent/broker/KPIF representative listed below to share enrollment, disenrollment, and summary plan information specific to this application with Kaiser Foundation Health Plan of Georgia, Inc. I understand that the person listed here may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of Georgia, 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.

To be completed by your agent/broker/KPIF representative after completion of this application:

I (the agent/broker/KPIF representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the *Evidence of Coverage* except through written materials furnished by Kaiser Foundation Health Plan of Georgia, Inc. The applicant has been informed that the effective date of coverage is assigned by Kaiser Foundation Health Plan of Georgia, Inc. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agent/Broker/KPIF representative (first, middle, last) (please print)

Deborah LB Reed

Agent/Broker/KPIF representative ID number

F83

Agency name

Lanao, Ltd.

Phone

770-751-8720

Fax

770-751-1806

Email address

deborahreed@reedinsurancegroup.com

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-888-865-5813** (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, or sex, you can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (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 **1-888-865-5813**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-888-865-5813** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

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。**1-888-865-5813**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-865-5813** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-865-5813** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (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 **1-888-865-5813** (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 **1-888-865-5813** (TTY: **711**).