KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St. • P.O. Box 6306 • Rockville, MD 20849

INDIVIDUAL ENROLLMENT APPLICATION & CHANGE FORM

Important: Please read these instructions before you complete the application on the next page.

Welcome to Kaiser Permanente! We look forward to you becoming a valued member of Kaiser Permanente. If you have any questions about enrolling in Kaiser Permanente, call Member Services at (301) 468-6000, (800) 777-7902, toll free outside of the Washington Metro Calling Area, or (301) 816-6344, TDD.

Please complete and sign this form.

If you are Medicare-eligible, there is a separate enrollment process. Call Member Services for information.

How to Complete This Application

Please print all information.

Section 1: Select your enrollment status and plan.

Use this form to enroll or change (add or delete) your family members' membership status. To be a subscriber, you must live or work within our Service Area when you initially enroll.

Section 2: Please tell us about yourself and enclose your certificate of creditable coverage. If you are applying under the Health Insurance Portability and Accountability Act (HIPAA), remember to check the box regarding HIPAA eligibility.

Section 3A: Please tell us about your dependents.

Section 3B: Select a primary care personal physician (PCP) for yourself and each dependent.

To select a primary care physician please review Kaiser Permanente's provider directory of physicians and other health care professionals. Enter the provider code of the primary care physician you and each member of your family selects. If you need a directory or assistance, please call Member Services at:

Washington, DC Metro Calling Area	(301) 468-6000
Outside Washington, DC Metro Calling Area	(800) 777-7902
TDD	(301) 816-6344

Section 4: About other insurance.

Tell us if you, your spouse, or other family dependents are covered by other health insurance plans.

Some families have health coverage under two separate health plans. For example, this may occur when both spouses are employed and have health care benefits from different carriers.

If you and/or your family are covered by more than one health plan, you may be able to save money while improving your coverage. If you are covered by two plans that include a Coordination of Benefit (COB) provision, you can eliminate most of your out-of-pocket expenses for services now only partially covered by those plans.

When you receive services authorized by Kaiser Permanente, we will bill your primary carrier for you and set up a benefit reserve account. Kaiser Permanente will keep track of any savings we receive from your primary carrier and credit it into a benefit reserve account for you. The money in the benefit reserve account is used to reimburse you for out-of-pocket expenses for medical services that are only partially covered by either one of your health plans. Incurred expenses and credits to the benefit reserve account must occur in the same calendar year.

If you qualify for Coordination of Benefits, your signature on this application gives Kaiser Permanente permission to coordinate benefits with your alternate carrier. For more information on Coordination of Benefits, please call Member Services.

Section 5: Review and sign your application.

Keep a copy of this application as verification of enrollment or change until you receive your member ID card. Before you sign this application, please make certain you have read all coverage materials and have selected a primary care physician. Failure to complete all relevant parts of the application may delay or prevent enrollment and the issuance of a member ID card.

Receiving Care After Enrollment

Your member ID card should arrive shortly after your effective date. However, if you do not receive a member ID card, you and your covered dependents can still receive services through Kaiser Permanente as of your effective date of coverage. Call Member Services for more information.

Here are important telephone numbers to keep handy until your member identification card arrives:

Member Services:

Washington, DC Metro Calling Area	(301) 468-6000
Outside Washington, DC Metro Calling Area	(800) 777-7902
TDD	(301) 816-6344

To schedule an appointment or to receive medical advice, call:

Washington, DC Metro Calling Area:	(703) 359-7878 or (703) 359-7616, TDD
Outside Washington, DC Metro Calling Area:	(800) 777-7904 or (800) 700-4901, TDD
For 24-hour emergency assistance, call:	(800) 677-1112 or (800) 365-9123, TDD

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INDIVIDUAL ENROLLMENT APPLICATION & CHANGE FORM

1 Select Your Type of Enrollment

Effective date _____ month _____ day _____ year

For Official Use Only:
Group Number: __ __ __ __ __ __ __ __ __ __ __ __
Date Received:
Rep Initials:

❑ **New Enrollment** or
❑ **Change Enrollment** ❑ Add dependent ❑ Delete dependent ❑ Other:________

2 Tell Us About Yourself

Subscriber Name (last, first, middle)

Date of Birth: _____ month _____ day _____ year Sex: ❑ Male ❑ Female

Home Street Address

City State Zip

Telephone No. (Home)( ) Work( ) Ext.

Social Security No.:

Your Employer's Name:

Street Address:

City State Zip

❑ I am eligible and applying for coverage under the Health Insurance Portability and Accountability Act (HIPAA). I am enclosing a copy of Certificate of Creditable Coverage with this Application. (To determine if you are eligible for coverage under HIPAA, please refer to the enclosed HIPAA eligibility guidelines.)

3 Tell Us A&B About Your Dependents & Select a Primary Care Physician (PCP)

(A.) Name, Last, First, Middle Initial	Sex (M F)	Social Security #	Date of Birth (Month Day Year)	**(B.)** Primary Care Physician Provider Code
S E L F				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

Have you or any of your dependents listed above ever been members of Kaiser Permanente before? ❑ Yes ❑ No If yes, indicate current name and name under which each was covered, if different: ______________________________

4 Tell Us About Other Insurance Coverage

Are you or any member of your family covered by another group health insurance plan? ❑ Yes ❑ No If yes, indicate:

Name and Phone # of Plan ______________________________

Policy #________________ Group # __________ Persons Covered ______________________________

Effective Date _____ month _____ day _____ year Termination Date (if applicable) _____ month _____ day _____ year

Name and Phone # of Employer Who Provides Coverage ______________________________

5 Please Review and Sign Your Name

I hereby apply for membership in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. or change in membership status for myself and any eligible dependents.

I hereby assign Health Plan authorization to bill my/spouse's primary group insurance plan for all covered services provided or arranged by physicians with said Plan so long as I am a member of said Plan and such group plan is primary to Health Plan under Coordination of Benefits provisions. I understand that this coordination of benefits does not limit my rights to receive reimbursement for services I receive from non-Plan physicians.

I understand that my coverage and my benefits may be affected by failure to provide complete and accurate information of a material nature.

By signing my signature below, I am authorizing any physician, nurse, hospital or other provider (hereafter "Provider") having treated or attended me or any of my family members listed on this application, and having possession of any records or information with respect thereto, is authorized and directed to provide such information or records to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. upon request for the purpose of evaluation of this application. This authorization is valid for 30 months.

If this application is approved by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., by signing my signature below, I authorize any Provider to forward Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. information concerning medical services or supplies provided to me or to any of my family listed on this application for the purposes of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services Representative before signing the application or card. Call (301) 468-6000, 1-800-777-7902, toll free outside of the Washington Metro Calling Area, or (301) 816-6344, TDD.

Stop! Before you sign this application, make sure you have filled it out completely including selecting a primary care physician for you and each of your enrolled dependents.

It is the policy of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. to protect privacy by means of an active confidentiality process which includes limits on access, controlled circulation, and security of patient records and information. All personal and health information will be treated in a confidential manner in compliance with applicable state and federal laws, and accreditation standards.

Signature of Applicant (Subscriber) Date of Application

Original Copy: Kaiser Permanente Membership Accounting Yellow Copy: Kaiser Permanente Marketing Pink Copy: Kaiser Permanente Marketing Gold Copy: Applicant