KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852

Payment Form

Section 1: Application Type
Please check one:
___ New Application ___ Adding Dependent(s)

Section 2: Payment Type
For Credit Card Payment please check one:
___American Express ___Discover ___MasterCard ___Visa

Credit Card number: ____________________________ Expiration Date:__________
Authorized amount: _________________________________
Name as it appears on the card: ____________________________________
Signature: ____

For payment by checks (please note that there is a $35 fee for insufficient fund returns):
Check number: __________________
Amount: __________________

Section 3: For adding Dependent(s) only:

Please note that if you are adding a spouse, include a copy of your marriage license, or if you live in Maryland or the District of Columbia and are applying for a domestic partner, include an affidavit of domestic partnership. If you are adding a child include a copy of a birth certificate, adoption or guardian order (excluding newborns enrolled prior to 31 days).

Names of dependent(s):

_________________________ ____________________________

_________________________ ____________________________

_________________________ ____________________________

Reason for adding: ____

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Current Premium: _______________
Adjusted Premium to include dependent(s): _______________
Difference to be submitted: _______________

For internal use only (Underwriting)	**For internal use only** (Membership Accounting)
Group number: ________________ **Sub-group number:** ________________ **Date:** ________________ **Premium:** ________________ **Enrollment month:** ________________	**Family Number:**______________________