Enrolling is Simple.
Just Follow These 2 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: **800-260-9051** fax: **888-554-8312**

Step 2

SEND THE COMPLETED APPLICATION TO:

Nicole Pennington
530 Los Angeles Ave #115-189
Moorpark, CA 93021

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 800-260-9051

Thank you for choosing...

KAISER PERMANENTE

KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: Use this form to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan. Please answer all questions and print or type **using ink only**. You should sign this application only if you understand each question and agree to the response provided—even if a broker assists you with the application.

If you have questions about completing this application (in English or another language), please call 1-800-634-4579. We will provide translation services and other language assistance free of charge if you need it. Or, if you are working with a broker, please call him or her for assistance.

You may use this application to apply for individual coverage provided by Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC). **If family members want to apply for coverage provided by KFHP or KPIC, each will need to fill out a separate application.**

Mail your completed application to:
Kaiser Permanente for Individuals and Families
P.O. Box 7104
Pasadena, CA 91109

Or send it by secure fax to **866-816-5139**.

I Application for Coverage (financially responsible party)

Last name

First name MI

Residential address for covered party:

Street address Apt./Unit #

City State ZIP

( ) ☐ Day ☐ Evening
Home phone

( ) ☐ Day ☐ Evening
Work phone

E-mail address

How do you prefer to be contacted? ☐ E-mail ☐ U.S. mail

Primary spoken language:
☐ English
☐ Other (please specify)_____

II Account Information

Please check all boxes that apply.

1. **Are you adding a family member to your current individual plan account with family coverage? If accepted, your family member will be added to your current plan.**

   ☐ Yes ☐ No

   Medical record number and plan name of your current individual plan account _____

   If you answered *Yes*, please provide your medical record number in the space above and skip to question 6.

2. **Are you switching coverage/plan selection from a current individual plan account?**

   ☐ Yes ☐ No

   Medical record number and plan name of your current individual plan account _____

   If you answered *Yes*, please provide your medical record number in the space above and skip to question 4.

3. **Are you applying for a new KPIF account?**

   ☐ Yes ☐ No

(continues on page 2)

II Account Information *(continued)*

4. Which plan would you like to apply for? (Select only one plan.)

Plans offered by KFHP:[1]

- ☐ Copayment 25
- ☐ Copayment 40
- ☐ Copayment 50
- ☐ Deductible 20/500
- ☐ Deductible 25/1000
- ☐ Deductible 30/1500
- ☐ Deductible 40/2000
- ☐ Deductible 0/1500 with HSA
- ☐ Deductible 0/2700 with HSA
- ☐ Deductible 30/2700 with HSA

Plans offered by KPIC:[1]

- ☐ Deductible 40/3000 NM
- ☐ Deductible 50/5000 NM
- ☐ Deductible 40/4000 NM with HSA
- ☐ Deductible 0/5000 WM with HSA

5. Are you applying for the optional dental plan?

- ☐ Yes, I would like to enroll in the KPIC Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.
- ☐ No

6. Effective date:

If approved, I would like to be enrolled with an effective date of:

- ☐ 15th of the current month (Your application must be received by the 8th of the current month.)
- ☐ 1st of the next month (Your application must be received by the 23rd of the current month.)
- ☐ 15th of the next month (Your application must be received by the 8th of the next month.)
- ☐ 1st of the month after the next (Your application must be received by the 23rd of the next month.)

Note: All applications must be accompanied by a credit/debit card payment for the first month's premium. Please make certain that you have provided the necessary information on page 17 of this application. Premiums for enrollments beginning on the 15th of the month will be prorated for that month only, after which the standard billing cycle (1st of the month) will apply.

You may not qualify for the plan you request at the standard rate. However, you may qualify for that plan at a higher rate or for a different plan. If so, we will enroll you in the requested plan at the higher rate, or the closest plan for which you qualify. We will notify you of the plan or rate change with your acceptance letter. You will be permitted to cancel your enrollment without financial penalty.

If you do not qualify for any KPIF plan, you may qualify for a HIPAA plan without medical review. Please review and complete Section IX, "HIPAA Eligibility Questionnaire and Request for Enrollment," on pages 23–24.

[1]For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* or *Certificate of Insurance* for a particular plan, please call us at 1-800-634-4579 or contact your broker.

III Applicant To Be Covered

You may use this application to apply for KFHP or KPIC coverage as an individual. If your family members want to apply for coverage, each must complete a separate application.

Applicant:

Last name _____ First name _____ Previous name (if any) _____ Date of birth _____ M/F _____

Height (ft/in) _____ Weight (lbs) _____ Marital status _____ Current or previous Kaiser Permanente medical record number (if any) _____

Social Security number _____ Primary spoken language: ☐ English ☐ Other (please specify) _____

Provide the information below for the Applicant's current or most recent primary care physician, along with his or her address.

Doctor _____

Phone _____

Date last visited _____

Address _____

City, State, ZIP _____

Provide the information below for the Applicant's current or most recent health coverage provider.

Health coverage provider: _____

☐ Current **or** Date ended ____ / ____ / _____ **or** ☐ Not insured

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a member of KFHP or insured by KPIC. **Each Applicant for a KFHP plan or a KPIC insurance policy must undergo medical review regardless of current or previous Kaiser Permanente coverage through KFHP or KPIC.** Omissions or incomplete answers regarding your or, if applicable, your family member's health history will delay processing of the application. **Either intentional or willful misrepresentation of an Applicant's health history can result in rescission of coverage for that Applicant (see Section VIII for details).**

This application becomes part of the Applicant's Kaiser Permanente record. If you need assistance completing this medical questionnaire, you may call your broker. Kaiser Permanente does not discriminate in its decision-making based on: race; color; national origin; ancestry; religion; sex (including gender, gender identity, or gender-related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth); marital status; sexual orientation; age; or genetic information.

You must answer each question and subquestion. Please answer *Yes, No,* or *Not sure (NS)* to each question. (*You* in the questionnaire refers to the Applicant.) Mark *Not sure (NS)* only if you do not understand the question being asked, do not understand the medical terms being used, do not know if you have or have had this condition, cannot remember when you had the condition listed or experienced symptoms, don't remember the date that you consulted a physician or were admitted to a hospital, or don't remember the information that you need to provide in order to answer the question correctly. Each question for which you answer *Yes* or *Not sure (NS)* requires an explanation. Please see the charts on pages 11–15 and provide the information requested. We may need to contact you for further explanation if you answered *Yes* or *Not sure* to any questions.

If you need help completing this application, please call your broker.

1. ***Within the last 12 months***, were you hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?
   ☐ Yes ☐ No ☐ NS

2. ***Within the last 12 months***, have you sought advice or treatment from a medical professional's office?
   - ☐ Yes ☐ No ☐ NS a) Physical exam
   - ☐ Yes ☐ No ☐ NS b) Minor illness or injury now resolved and without a recommendation of further treatment; for example, cold, allergic reaction, flu, sore throat, cut requiring stitches
   - ☐ Yes ☐ No ☐ NS c) Chiropractic visits
   - ☐ Yes ☐ No ☐ NS d) Prenatal care
   - ☐ Yes ☐ No ☐ NS e) Psychological counseling
   - ☐ Yes ☐ No ☐ NS f) Medication management
   - ☐ Yes ☐ No ☐ NS g) A reason not listed above

3. ***Within the last 3 years***, have you been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?
   ☐ Yes ☐ No ☐ NS

4. ***Within the last 3 years***, have you been instructed to attend, attended, or participated in a program that deals with ***your*** alcohol or substance abuse?
   ☐ Yes ☐ No ☐ NS

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

5. ***Within the last 3 years***, have you been treated for, or has a medical professional advised you that you have, any skin/dermatological disorders?

☐ Yes ☐ No ☐ NS a) Acne
☐ Yes ☐ No ☐ NS b) Psoriasis
☐ Yes ☐ No ☐ NS c) Burns
☐ Yes ☐ No ☐ NS d) Keloids requiring plastic surgery
☐ Yes ☐ No ☐ NS e) Cosmetic or reconstructive surgeries, revisions
☐ Yes ☐ No ☐ NS f) A skin or dermatological condition not listed above

6. ***Within the last 3 years***, have you been treated for, or has a medical professional advised you that you have, any disorders of the eyes, ears, nose, or throat?

☐ Yes ☐ No ☐ NS a) Glaucoma
☐ Yes ☐ No ☐ NS b) Cataracts, cataract surgery for one or both eyes
☐ Yes ☐ No ☐ NS c) Crossed eyes
☐ Yes ☐ No ☐ NS d) Detached retina
☐ Yes ☐ No ☐ NS e) Macular degeneration
☐ Yes ☐ No ☐ NS f) Deviated septum
☐ Yes ☐ No ☐ NS g) Sleep apnea, chronic snoring, or unresolved insomnia
☐ Yes ☐ No ☐ NS h) Nasal and/or throat polyps
☐ Yes ☐ No ☐ NS i) A condition of the eyes, ears, nose, or throat not listed above

7. Have you ever used tobacco, including snuff and chewing or other smokeless tobacco?

☐ Yes ☐ No ☐ NS
a) If *Yes*, how many years? _____
☐ Yes ☐ No ☐ NS b) Have you stopped using tobacco products?
c) If *Yes*, how many years ago did you quit? _____
d) If you smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:
Cigarettes: ____ packs per day
Pipes: _____ bowls per day
Cigars: _____ per day

8. ***Within the last 5 years***, have you taken or used illegal drugs or prescription drugs not prescribed by a medical professional?

☐ Yes ☐ No ☐ NS

9. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any brain, neurological, or nervous disorder?

☐ Yes ☐ No ☐ NS a) Multiple sclerosis
☐ Yes ☐ No ☐ NS b) Autism
☐ Yes ☐ No ☐ NS c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
☐ Yes ☐ No ☐ NS d) Seizures treated with more than 2 medications for control
☐ Yes ☐ No ☐ NS e) Seizures under control with 2 or fewer medications
☐ Yes ☐ No ☐ NS f) Most recent seizure within the last 12 months
☐ Yes ☐ No ☐ NS g) Alzheimer's disease
☐ Yes ☐ No ☐ NS h) A brain, neurological, or nervous disorder not listed above

(Medical questionnaire continues on page 6.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

10. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any heart or cardiovascular disorders?

- ☐ Yes ☐ No ☐ NS a) Aneurysm
- ☐ Yes ☐ No ☐ NS b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment
- ☐ Yes ☐ No ☐ NS c) Chest pain
- ☐ Yes ☐ No ☐ NS d) Heart attack or angina
- ☐ Yes ☐ No ☐ NS e) Congestive heart failure
- ☐ Yes ☐ No ☐ NS f) Angioplasty or coronary artery bypass
- ☐ Yes ☐ No ☐ NS g) Pacemaker
- ☐ Yes ☐ No ☐ NS h) Tachycardia or other heart arrhythmia
- ☐ Yes ☐ No ☐ NS i) Other heart disease or valve disease
- ☐ Yes ☐ No ☐ NS j) Current medication(s) to control heart disease or cardiovascular symptoms
- ☐ Yes ☐ No ☐ NS k) A heart or cardiovascular condition not listed above

11. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any respiratory disorders?

- ☐ Yes ☐ No ☐ NS a) Chronic asthma treated with medications for control
- ☐ Yes ☐ No ☐ NS b) Asthma treated with prednisone therapy
- ☐ Yes ☐ No ☐ NS c) Asthma treated only with occasional use of inhalers
- ☐ Yes ☐ No ☐ NS d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months
- ☐ Yes ☐ No ☐ NS e) Emphysema
- ☐ Yes ☐ No ☐ NS f) Chronic bronchitis
- ☐ Yes ☐ No ☐ NS g) Chronic obstructive pulmonary disease
- ☐ Yes ☐ No ☐ NS h) Cystic fibrosis
- ☐ Yes ☐ No ☐ NS i) Pulmonary tuberculosis, active or arrested
- ☐ Yes ☐ No ☐ NS j) A lung or respiratory disorder not listed above

12. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any muscle or bone disorders?

- ☐ Yes ☐ No ☐ NS a) Back or neck pain or injury currently under treatment or controlled with medication
- ☐ Yes ☐ No ☐ NS b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment
- ☐ Yes ☐ No ☐ NS c) Back or neck pain or injury for which further treatment or surgery has been recommended
- ☐ Yes ☐ No ☐ NS d) Inguinal hernia that has been repaired
- ☐ Yes ☐ No ☐ NS e) Inguinal hernia not repaired
- ☐ Yes ☐ No ☐ NS f) Umbilical hernia that has been repaired
- ☐ Yes ☐ No ☐ NS g) Umbilical hernia not repaired
- ☐ Yes ☐ No ☐ NS h) Lupus/SLE
- ☐ Yes ☐ No ☐ NS i) Chronic disabling arthritis
- ☐ Yes ☐ No ☐ NS j) Arthritis requiring daily prescription medication
- ☐ Yes ☐ No ☐ NS k) Osteomyelitis
- ☐ Yes ☐ No ☐ NS l) Joint replacement surgery
- ☐ Yes ☐ No ☐ NS m) Orthopedic or arthritic conditions that interfere with daily living (Examples of daily living include bathing, dressing, grooming, or walking.)
- ☐ Yes ☐ No ☐ NS n) A musculoskeletal condition not listed above

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

13. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any metabolic or endocrine (hormone) disorders?

☐ Yes ☐ No ☐ NS a) AIDS

California law prohibits an HIV test from being required or used by health care service plans or health insurance companies as a condition of obtaining coverage.

☐ Yes ☐ No ☐ NS b) Diabetes controlled with oral medication
☐ Yes ☐ No ☐ NS c) Diabetes controlled with insulin
☐ Yes ☐ No ☐ NS d) Diabetes controlled exclusively with diet and exercise
☐ Yes ☐ No ☐ NS e) Gestational diabetes
☐ Yes ☐ No ☐ NS f) High cholesterol
☐ Yes ☐ No ☐ NS g) Rheumatoid arthritis
☐ Yes ☐ No ☐ NS h) Muscular dystrophy
☐ Yes ☐ No ☐ NS i) Other immunological condition
☐ Yes ☐ No ☐ NS j) A metabolic or endocrine disorder not listed above

14. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any congenital defects or developmental disorders?

☐ Yes ☐ No ☐ NS a) Down syndrome
☐ Yes ☐ No ☐ NS b) Cerebral palsy
☐ Yes ☐ No ☐ NS c) Cleft palate or lip
☐ Yes ☐ No ☐ NS d) Club foot
☐ Yes ☐ No ☐ NS e) Congenital heart defect (specify type on pages 12–15)
☐ Yes ☐ No ☐ NS f) Developmental delay
☐ Yes ☐ No ☐ NS g) Prematurity (for children up to 2 years old)
☐ Yes ☐ No ☐ NS h) A neurological or physical abnormality not listed above (specify on pages 12–15)

15. For males only: ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any of the following:

☐ Yes ☐ No ☐ NS a) Prostate condition requiring treatment, medication, or surgery
☐ Yes ☐ No ☐ NS b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months
☐ Yes ☐ No ☐ NS c) Genital warts
☐ Yes ☐ No ☐ NS d) Syphilis
☐ Yes ☐ No ☐ NS e) Gonorrhea
☐ Yes ☐ No ☐ NS f) Other sexually transmitted disease
☐ Yes ☐ No ☐ NS g) Impotence or erectile dysfunction
☐ Yes ☐ No ☐ NS h) Infertility
☐ Yes ☐ No ☐ NS i) Gender identity (role) disorder
☐ Yes ☐ No ☐ NS j) A male reproductive or genital disorder not listed above

(Medical questionnaire continues on page 8.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

16. For females only: ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any of the following:

- ☐ Yes ☐ No ☐ NS a) Ovarian cyst operated on within the last 12 months
- ☐ Yes ☐ No ☐ NS b) Ovarian cyst controlled by birth control pills
- ☐ Yes ☐ No ☐ NS c) Polycystic ovary syndrome (PCOS)
- ☐ Yes ☐ No ☐ NS d) Endometriosis
- ☐ Yes ☐ No ☐ NS e) Chronic pelvic pain or pelvic inflammatory disease
- ☐ Yes ☐ No ☐ NS f) Painful or irregular menstrual cycles
- ☐ Yes ☐ No ☐ NS g) Uterine fibroids
- ☐ Yes ☐ No ☐ NS h) Silicone breast implants
- ☐ Yes ☐ No ☐ NS i) Saline breast implants
- ☐ Yes ☐ No ☐ NS j) Infertility
- ☐ Yes ☐ No ☐ NS k) Miscarriage within the last 12 months
- ☐ Yes ☐ No ☐ NS l) Abnormal Pap test
- ☐ Yes ☐ No ☐ NS m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months
- ☐ Yes ☐ No ☐ NS n) Genital warts
- ☐ Yes ☐ No ☐ NS o) Syphilis
- ☐ Yes ☐ No ☐ NS p) Gonorrhea
- ☐ Yes ☐ No ☐ NS q) Other sexually transmitted disease
- ☐ Yes ☐ No ☐ NS r) In vitro fertilization
- ☐ Yes ☐ No ☐ NS s) Heavy periods (menstruation) causing low blood iron
- ☐ Yes ☐ No ☐ NS t) Gender identity (role) disorder
- ☐ Yes ☐ No ☐ NS u) A female reproductive or genital disorder not listed above

17. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any digestive system disorders?

- ☐ Yes ☐ No ☐ NS a) Ulcerative colitis or Crohn's disease
- ☐ Yes ☐ No ☐ NS b) Gastrointestinal bleeding
- ☐ Yes ☐ No ☐ NS c) Gastrointestinal polyps
- ☐ Yes ☐ No ☐ NS d) Unrepaired cystocele or rectocele
- ☐ Yes ☐ No ☐ NS e) Gallstones and gallbladder has not been removed
- ☐ Yes ☐ No ☐ NS f) Hepatitis A, B, C, or other, currently under treatment
- ☐ Yes ☐ No ☐ NS g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)
- ☐ Yes ☐ No ☐ NS h) Cirrhosis
- ☐ Yes ☐ No ☐ NS i) Hepatitis A, fully recovered with no symptoms and normal liver function tests
- ☐ Yes ☐ No ☐ NS j) Other liver condition
- ☐ Yes ☐ No ☐ NS k) A digestive system disorder not listed above

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

18. ***Within the last 5 years***, have you been treated for, or has a medical professional advised you that you have, any urinary tract disorders?

- ☐ Yes ☐ No ☐ NS a) Chronic kidney failure
- ☐ Yes ☐ No ☐ NS b) Nephrotic syndrome
- ☐ Yes ☐ No ☐ NS c) Polycystic kidneys
- ☐ Yes ☐ No ☐ NS d) Kidney failure
- ☐ Yes ☐ No ☐ NS e) Chronic kidney infections (more than 2 per year)
- ☐ Yes ☐ No ☐ NS f) Kidney infection, resolved with no further treatment required
- ☐ Yes ☐ No ☐ NS g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests
- ☐ Yes ☐ No ☐ NS h) Kidney removed with a recommendation for further treatment
- ☐ Yes ☐ No ☐ NS i) Kidney stones, currently
- ☐ Yes ☐ No ☐ NS j) Kidney stones within the last 24 months
- ☐ Yes ☐ No ☐ NS k) Interstitial cystitis
- ☐ Yes ☐ No ☐ NS l) A kidney or urinary tract disorder not listed above

19. ***Within the last 5 years***, has a medical professional advised you that you have any abnormal lab results?

☐ Yes ☐ No ☐ NS

If *Yes*, please provide the names of tests, results, and dates on pages 12–15.

20. ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any blood or circulatory system disorders?

- ☐ Yes ☐ No ☐ NS a) Stroke
- ☐ Yes ☐ No ☐ NS b) Transient ischemic attacks (TIA)
- ☐ Yes ☐ No ☐ NS c) Hemophilia
- ☐ Yes ☐ No ☐ NS d) Thalassemia major
- ☐ Yes ☐ No ☐ NS e) Von Willebrand's disease
- ☐ Yes ☐ No ☐ NS f) Other blood disorder
- ☐ Yes ☐ No ☐ NS g) Blood pressure over 150/90
- ☐ Yes ☐ No ☐ NS h) Currently taking 3 or more medications for hypertension
- ☐ Yes ☐ No ☐ NS i) Hypertension under control with medication
- ☐ Yes ☐ No ☐ NS j) A blood or circulatory system disorder not listed above

21. ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any cancer?

- ☐ Yes ☐ No ☐ NS a) Any cancer with lymph node involvement or metastasis (spread to other tissue)
- ☐ Yes ☐ No ☐ NS b) Cancer of the brain, breast, blood, pancreas, prostate, urinary bladder, or esophagus; or myeloma, Kaposi's sarcoma, or non-Hodgkin's lymphoma
- ☐ Yes ☐ No ☐ NS c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended
- ☐ Yes ☐ No ☐ NS d) Cancer of the colon, kidney, liver, lung, ovary, or stomach
- ☐ Yes ☐ No ☐ NS e) Skin cancer that has not been removed and requires further treatment
- ☐ Yes ☐ No ☐ NS f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended
- ☐ Yes ☐ No ☐ NS g) Melanoma
- ☐ Yes ☐ No ☐ NS h) A cancer not listed above

(Medical questionnaire continues on page 10.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

22. ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?

☐ Yes ☐ No ☐ NS

23. ***Within the last 10 years***, have you been treated for, or has a medical professional advised you that you have, any psychological or mental health disorders?

☐ Yes ☐ No ☐ NS	a) Mild depression/anxiety
☐ Yes ☐ No ☐ NS	b) Major depression or neurosis
☐ Yes ☐ No ☐ NS	c) Situational stress, anxiety, or depression no longer requiring treatment or medication
☐ Yes ☐ No ☐ NS	d) Eating disorder (anorexia nervosa or bulimia)
☐ Yes ☐ No ☐ NS	e) Suicide attempt
☐ Yes ☐ No ☐ NS	f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia
☐ Yes ☐ No ☐ NS	g) Hospitalization for a mental health condition
☐ Yes ☐ No ☐ NS	h) A psychological or mental health condition not listed above

24. Are you taking any prescription medications?

☐ Yes ☐ No ☐ NS

If *Yes*, please list the medication(s), the dosage/frequency, the reason for taking this medication, and the name/address/phone number of the prescribing medical professional on the chart on page 11.

25. Do you drink alcoholic beverages?

☐ Yes ☐ No ☐ NS

If *Yes*, please indicate how much you drink ***per week***:

a) Beer: _____ bottles/cans

b) Wine: _____ glasses

c) Hard liquor: _____ drinks

On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.

26. Are you ***currently*** pregnant or an expectant father? Or, do you ***expect to be providing*** medical insurance coverage for a newborn or new adoptee within the next 9 months?

☐ Yes ☐ No ☐ NS

27. Do you plan to be a surrogate parent (mother or father) ***within the next year*** or to engage someone to provide that service ***within the next year***?

☐ Yes ☐ No ☐ NS

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

28. For females age 11 and older:

☐ Yes ☐ No ☐ NS a) Have you ever menstruated?

☐ Yes ☐ No ☐ NS b) Are your menstrual periods regular? (If you answered *No*, please explain on pages 12–15.)

☐ Yes ☐ No ☐ NS c) Are you still having regular menstrual periods? (If you answered *Yes*, please indicate the date you started your last normal menstrual period on the charts on pages 12–15.)

29. ***Within the last 5 years***, have you been treated for, or advised that you have, a medical or health-related condition which you haven't indicated on this medical questionnaire? If so, please provide the appropriate details on the charts on pages 12–15.

☐ Yes ☐ No ☐ NS

Please fill in the chart below if you answered *Yes* to question **24**.

Name of prescription medication	Dosage/ Frequency	Reason for taking medication	Name/Address/Phone number of prescribing medical professional

(Medical questionnaire continues on page 12.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed or experienced symptoms but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

- ☐ I don't understand the question.
- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
- ☐ I had the condition listed or experienced symptoms but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

☐ I don't understand the question.
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☐ I don't know if I have or have had this condition.
☐ I had the condition listed or experienced symptoms but can't remember when.
☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

____

____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

____

____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

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- ☐ I don't understand the medical terms being used in the question.
- ☐ I don't know if I have or have had this condition.
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- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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- ☐ I had the condition listed or experienced symptoms but can't remember when.
- ☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
- ☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

Please fill in the charts below for each question answered or each condition marked ***Yes*** or ***Not sure (NS)*** in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

If you answered *Not sure* to this question, please check all boxes that apply.

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Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

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Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

____

____

Question #	Letter	Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)	Name of doctor giving diagnosis	Date of diagnosis

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☐ I don't know if I have or have had this condition.
☐ I had the condition listed or experienced symptoms but can't remember when.
☐ I don't remember the date that I consulted a physician or was admitted to a hospital.
☐ I don't remember the information that I need to provide in order to answer the question correctly.

Please provide a complete explanation of why you answered ***Not sure***. Attach additional pages if necessary.

____

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V Agent, Broker, and Representative Information

FOR APPLICANTS USING AN INSURANCE AGENT/BROKER/REPRESENTATIVE

Agent/Broker/Representative name _____

(*Representative* means any representative of KFHP or KPIC who has provided you with assistance.)

The broker of record may receive monetary and/or non-monetary payments from Kaiser Foundation Health Plan, Inc., and/or Kaiser Permanente Insurance Company in connection with the purchase of this coverage.

Note: Premiums are the same whether or not you use an agent/broker/representative.

TO BE COMPLETED BY YOUR KAISER PERMANENTE–APPOINTED AGENT/BROKER/REPRESENTATIVE AFTER COMPLETION OF THIS APPLICATION

You must answer the following question by selecting *Yes* or *No*:

I assisted the Applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant understood the explanation.

☐ Yes ☐ No

Notice to agent, broker, representative: If you have assisted the Applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

X _____

Agent/Broker/Representative signature (Use ink only.) **Today's date**

Nicole Pennington

Name of agent/broker/representative (please print)

455677948

Broker ID #

530 Los Angeles Ave #115-189

Address

Moorpark, CA 93021

City State ZIP

800-260-9051 **888-554-8312**

Phone Fax

E-mail address

VI Billing Information

Application must be accompanied by payment information for your initial premium. Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

Last name

First name MI

Street address Apt./Unit #

City State ZIP

2. Credit/Debit card information: ☐ Credit ☐ Debit

☐ Visa ☐ Discover
☐ MasterCard ☐ American Express

Cardholder's name as it appears on card

Credit/Debit card number

Expiration date

(This page is intentionally left blank.)

VII Authorization to Release Medical Information

All Applicants: Please read the following information and sign in the space(s) provided on the following page.

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* (for purposes of Section VII, *Applicant* is defined as me or any family member applying for or having membership in any KFHP or KPIC product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente 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, or AIDS [acquired immune deficiency syndrome]). 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 authorize Kaiser Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected (except for any Applicant under the age of 19 who must be accepted under applicable law); if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for 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, Kaiser Permanente may request, use, and disclose Medical Information, AIDS-related information, and psychotherapy notes. Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed. I understand that, under California law, the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

(continues on page 20)

VII Authorization to Release Medical Information *(continued)*

This authorization is effective on the date that the Applicant signs the application and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by Kaiser Permanente 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 KFHP Plan or insured by KPIC. A photocopy of this authorization is as valid as the original, and I and my Kaiser Permanente 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 Kaiser Permanente has already taken action in reliance on it, or for so long as Kaiser Permanente may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's *Notice of Privacy Practices*.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 12)

X _____

Applicant (age 12 or over) **Today's date**

Important: required signatures

- An Applicant age 18 and over must sign and date above on the appropriate signature line.
- An Applicant age 12–17 must sign and date above on the appropriate signature line. (Minors have the right to control the release of certain types of medical history and records. We require that such minors sign in addition to their parents or legal guardians.)

Signature by parent or legal guardian represents authorization for himself/herself as well as authorization for minor children.

Use ink only.

VIII Conditions of Acceptance/Arbitration Agreement

All Applicants: Please read the following information and sign in the space(s) provided on the following page.

You must fully answer each question in this application even though you may already be a KFHP member or a KPIC insured. If we decide to accept you for KFHP membership or issue you a KPIC policy, our decision will be based primarily on health information you provide in your application and during the enrollment process. If you have or previously had coverage with KFHP or with KPIC, we will review your prior health history with Kaiser Permanente before making our decision. We may review your use of health care services for up to a year following your KFHP or KPIC enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KFHP or KPIC enrollment.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or any other family member applying for coverage under this application, take the time to make sure the information is accurate before submitting it to us. By signing this application, you represent that all responses are true, complete, and accurate to the best of your knowledge, and that if KFHP or KPIC accepts your application for coverage, the application will become part of the plan contract between you and KFHP or KPIC.

Our decision to accept you or your family member (any Applicant under the age of 19 must be accepted under applicable law) for coverage will be made only after we have thoroughly reviewed the medical history information disclosed in Section IV of this application. Our review will include our reasonable efforts to verify the accuracy and completeness of the information disclosed in Section IV. We are under a duty to complete this process of review and verification of applicant health history information (medical review).

If we determine that you or someone on your behalf either intentionally or willfully gave us incomplete or incorrect material information about the current or past health of any person applying for coverage on this application (or if such intentional or willful misrepresentation of health history was made at any time during the enrollment process), and our decision to accept the enrollment was based on this misinformation, we may rescind the membership of the person whose health history was so misrepresented. Additionally, if we determine that you or someone on your behalf lied about your age or the nature of your relationship to the person who is financially responsible for your coverage, and our decision to accept your enrollment is based on this misinformation, we may rescind the membership of the person for whom we have received such false information. This means that we would completely void KFHP membership or the KPIC insurance policy of the misrepresenting individual as if no coverage had ever existed. If we approve the application for coverage for you or any other Applicant on this application without properly completing medical review, we may only rescind coverage if we can support a claim that health history information disclosed in Section IV, or material health information not disclosed, was willfully misrepresented or omitted.

Before making any decision to rescind, we would notify you in writing why we believe we have grounds to rescind your coverage. Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm your actual health status at the time you were accepted for enrollment. If, after considering your response, we decide to rescind, we will send written notice to you at least 30 days before the date we rescind your coverage, explaining the basis for our decision and how you can appeal it.

Please note: If the intentionally or willfully provided incomplete or incorrect material health history information relates only to another person on the application (for example, a family member) and not to you as the primary Applicant, our rescission would not affect you or any other family member on the application because your (or his/her) health history did not lead to our decision to rescind. Conversely, if the intentionally or willfully provided incomplete or incorrect material health history information relates to you only, any other person applying for coverage on this application would not be affected because his/her health history on the application did not lead to our decision to rescind. If the coverage is lawfully rescinded, the rescinded individual may have to reimburse us for the reasonable value of any services that we provided or that we paid for on your (his/her) behalf, if legally permitted. Please refer to the *Membership Agreement* or *Certificate of Insurance* for more information about rescission of membership in KFHP or KPIC. Within 30 days, we will refund all applicable premiums except that we may subtract any amounts you owe us.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf.

Important note to the Applicant: You or your authorized representative may request a copy of your completed application. For more information, please call **1-800-634-4579**.

(continues on page 22)

VIII Conditions of Acceptance/Arbitration Agreement *(continued)*

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation [29 CFR 2560.503-1], certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings.[1] I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement* and in the *Certificate of Insurance*.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 18)

X _____

Applicant (age 18 or over) **Today's date**

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

Use ink only.

[1]Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) KPIC Dental Plans.

For office use only:

Receive date: _____

❑ Accept ❑ Reject ❑ Rate ❑ Alternate Process date: _____

Effective date: _____ MRN/HRN listed in Section III, page 3

Purch-EU/Grp-Sbgrp: _____

IX HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for KFHP Individuals and Families Plan coverage or KPIC insurance coverage but meet all of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements and only if your KFHP or KPIC application is declined. If you qualify for HIPAA coverage and applied for and qualify for KFHP coverage, we will enroll you in the KFHP plan. If you qualify for HIPAA coverage and applied and qualify for KPIC coverage, we will enroll you in the KPIC plan. For information about your HIPAA eligibility, plan benefits, and rates, or if you want to request a copy of a *Membership Agreement*, please contact your broker.

Questionnaire

Please read the HIPAA requirements below to determine whether all five are true statements for you or, if applicable, your family member applying for coverage. Then read the declarations on page 24 and check the appropriate response for yourself or your family member. Your response on page 24 will instruct Kaiser Permanente whether you or your family member wish to enroll in a HIPAA plan in the event you or your family member do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. *Creditable coverage* means continuous health coverage during the qualifying 18-month period immediately preceding this application for enrollment. If there have been multiple coverages during that qualifying period and/or a combination of individual and group coverage, a) there can be a break of no more than 63 days between coverages, and b) the final coverage must have been group coverage. For more information about the types of health coverage that may qualify for creditable coverage, please refer to the *Membership Agreement*, or call us at the information number listed above.
2. My most recent health coverage was through a group health plan, a governmental plan, or a church plan.
3. If I was eligible for continuation of coverage under federal (COBRA) or state (Cal-COBRA) laws, I enrolled in any available continuation coverage and paid all applicable premiums for the entire period for which I was eligible.
4. I do not currently have other health coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was not terminated for fraud or failure to pay premiums.

(continues on page 24)

IX HIPAA Eligibility Questionnaire and Request for Enrollment *(continued)*

Read the declarations below regarding the five statements listed on page 23. Then indicate which declaration is true for you, or if applicable, your family member applying for coverage. **Check only one box for each family member applying.**

Print name(s). Use ink only.	All five statements are true. Enroll me in HIPAA if I do not qualify for a KFHP Individuals and Families plan or KPIC Individual plan.	All five statements are true. However, if I do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan, I do **not** want to be enrolled in HIPAA.	One or more of the five statements is false. I do not qualify for HIPAA.
Applicant/Financially responsible party	☐	☐	☐
Applicant (age 18 or over)	☐	☐	☐

If you selected a box in the first column, indicating that you or your family member want to be considered for HIPAA coverage, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Enrollment in HIPAA may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you or your family member will be enrolled for membership in HIPAA.

X _____

Applicant/Financially responsible party **Today's date**
(signing on behalf of self or Applicant under the age of 18)

X _____

Applicant (age 18 or over) **Today's date**

Use ink only.