



Kaiser Foundation Health Plan of the Northwest

Section 1 – Instructions

- Please use a **pen** to complete and sign this application.
- Make sure this application is complete and signed. A parent or legal guardian must sign the following on behalf of any child applicant under age 18: (1) the certification of completion and correctness, (2) the producer authorization (if applicable), and (3) the "Authorization to Obtain or Release Medical Information." Applicants who are age 15 or older must also sign the "Authorization to Obtain or Release Medical Information." Throughout this application, *I* and *you* refer to the Applicant, including when the Applicant is a child for whom a parent or legal guardian is signing. We are unable to process applications without appropriate signatures.
- If you would like help completing this application, please call **1-888-813-3700**.
- To be eligible for Kaiser Permanente Individuals and Families, you must live in our Northwest Oregon service area.
- **If this application contains any material misstatements or omissions, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. 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.**
- If you are eligible for Medicare, please call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

Section 2 – Enrollment information

Complete the following information **and** submit one application for **each** family member **applying**:

Applicant	Last name	First name	Middle initial	Previous name(s)	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single
Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Social Security number	Health record number (if any)
Address			City	State	ZIP
Home phone			Work phone		

Names of other family members submitting applications (This helps us to process family members together.)

Spouse/ Domestic partner*	Last name	First name	Middle initial	Date of birth	Previous name(s)
Child					
Child					
Child					

*A domestic partner is a person legally recognized as your domestic partner in a valid *Certificate of Registered Domestic Partnership* issued by the state of Oregon.

For official use only

Date received	<input type="checkbox"/> New account	<input type="checkbox"/> Reapplication	Effective date _____
	<input type="checkbox"/> Conversion	<input type="checkbox"/> Upgrade	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
	<input type="checkbox"/> Add-on		

Section 3 – Plan selection

Choose one Kaiser Permanente Individuals and Families plan

<p>Copayment plans</p> <p><input type="checkbox"/> Platinum Rx</p> <p><input type="checkbox"/> Platinum</p>	<p>Deductible plans</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Gold \$500</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Bronze \$1,500</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Gold \$1,000</td> <td style="border: none;"><input type="checkbox"/> Bronze \$2,500</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Silver \$1,500</td> <td style="border: none;"><input type="checkbox"/> Bronze \$3,500</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Silver \$2,500</td> <td style="border: none;"><input type="checkbox"/> Bronze \$5,000</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Silver \$3,500</td> <td style="border: none;"><input type="checkbox"/> Bronze \$7,500</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Silver \$5,000</td> <td style="border: none;"><input type="checkbox"/> \$5,000 Deductible (Child-only option)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Silver \$7,500</td> <td style="border: none;"><input type="checkbox"/> \$7,500 Deductible (Child-only option)</td> </tr> </table>	<input type="checkbox"/> Gold \$500	<input type="checkbox"/> Bronze \$1,500	<input type="checkbox"/> Gold \$1,000	<input type="checkbox"/> Bronze \$2,500	<input type="checkbox"/> Silver \$1,500	<input type="checkbox"/> Bronze \$3,500	<input type="checkbox"/> Silver \$2,500	<input type="checkbox"/> Bronze \$5,000	<input type="checkbox"/> Silver \$3,500	<input type="checkbox"/> Bronze \$7,500	<input type="checkbox"/> Silver \$5,000	<input type="checkbox"/> \$5,000 Deductible (Child-only option)	<input type="checkbox"/> Silver \$7,500	<input type="checkbox"/> \$7,500 Deductible (Child-only option)	<p>Deductible HSA plans</p> <p><input type="checkbox"/> \$1,500 Deductible/Rx with HSA Option</p> <p><input type="checkbox"/> \$1,500 Deductible with HSA Option</p> <p><input type="checkbox"/> \$2,600 Deductible/Rx with HSA Option</p> <p><input type="checkbox"/> \$2,600 Deductible with HSA Option</p>
<input type="checkbox"/> Gold \$500	<input type="checkbox"/> Bronze \$1,500															
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<input type="checkbox"/> Silver \$1,500	<input type="checkbox"/> Bronze \$3,500															
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<input type="checkbox"/> Silver \$7,500	<input type="checkbox"/> \$7,500 Deductible (Child-only option)															

Dental plan options: Plan 1 Plan 2 Plan 3

Please note: To enroll in the optional dental plan, you and your covered dependents must also be enrolled in the Health Plan.

Additional information is available upon request.

Please allow a minimum of 10 days for the processing of each completed application. Effective date of coverage cannot be more than **60 days** from the date the application is signed.

I am adding a new person to an existing Kaiser Permanente Individuals and Families account.

Subscriber's health record number

Note: Your plan options may be limited based on review of your application and medical history.

Section 4 – Prior or current coverage

This coverage has a six-month waiting period for pre-existing conditions. This means that we do not pay for expenses incurred by you or your enrolled dependent(s) for pre-existing conditions during the six months following your or your enrolled dependent's effective date of coverage. A *pre-existing condition* is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the pre-existing condition waiting period, please provide responses to **all** the information requested below. For questions about waiting periods or pre-existing conditions, call **1-888-813-3700**. For questions about prior or current coverage, call **1-503-813-2000**.

Details regarding current or prior coverage

1. Do you currently have insurance or have you had insurance in the past?
 - Yes
 - No
2. Name of insurance company _____
 Phone (_____) _____
3. Date coverage began _____
 Date coverage ended/ends _____
4. Type of coverage:
 - Group plan
 - Church plan
 - Individual plan
 - OMIP
 - Health options plan
 - Federal plan
(e.g., TRICARE, FEBHP, or Peace Corps Act)
 - Plan established/maintained by a foreign country or any political subdivision thereof
 - Plan of Indian Health Service or tribal organization
 - College, school, or short-term insurance
5. Deductible amount per year:
 - Individual _____
 - Family _____
6. Copayment and/or coinsurance _____
7. Coverage does or did include:
 - Maternity
 - Hospital only
 - Prescription drug
 - Waiting periods for organ transplants
 - None of the above
8. Names of individuals covered by current or prior insurer _____

9. Are you currently on or did you recently exhaust, terminate, or decline COBRA or state continuation coverage?
 - Yes
 - No
 If Yes, date coverage began _____
 Date coverage ended _____
10. Are you eligible for the following?
 - Medicare Part A or B Yes No
 - Medicaid Yes No
 If you answered Yes to Medicare, do not continue. Call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

Section 5 – Questionnaire

Oregon Standard Health Statement

(Standard form per ORS 743.766)

All questions must be answered to begin processing. Please mark Yes or No for each item. Provide details in the health history details section (No. 55) to any questions answered Yes.

(For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.)

Notice to applicant: You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Within the last 5 years, have you had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

- | | | | |
|---|--|---|--|
| 1. AIDS, ARC, HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Chronic headaches/migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/chemical/drug abuse/habit | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Heart/chest pain/angina | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Anemia/chronic fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. High cholesterol
(if Yes, record last reading in No. 55) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/neck/spine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure
(if Yes, record last reading in No. 55) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/congenital deformities | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/kidney stones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/urinary tract | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/shoulder/hip/other joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/circulatory | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition/hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/orthopedic | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. a. Mental/emotional condition/depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Therapy/counseling within last 5 years | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | (if Yes, record date of last session in No. 55) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chemotherapy/radiation treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/disease/injury | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. a. Colon/rectum/intestine/bowel | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/blood clot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/osteoporosis/osteopenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsions/seizures/epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/elevated PSA/prostatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/sugar in urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/infertility | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/nose/throat/tonsil condition/disease/disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/lung condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited to, anorexia or bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/asthma/chronic lung disease (COPD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/gland/hormone system | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous moles, or eczema/cysts/cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of eye/cataract/glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 22. Gallbladder/pancreatic disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Note: All questions must be answered to begin processing.

- 42. Sleep apnea/chronic sleep disorder Yes No
- 43. Stomach disorders/ulcer/acid reflux Yes No
- 44. Stroke/paralysis/seizures Yes No
- 45. Tumors Yes No
- 46. TMJ/jaw joint Yes No
- 47. Weight fluctuation (+/- 20 lbs.) Yes No
- 48. Cosmetic surgery/implants, use of prosthetic devices/limbs Yes No
- 49. a. Have you used tobacco products in any form within the last 5 years? Yes No
 b. If Yes, please list each type of product(s): _____

- 50. For females only—please provide the following information:
 - a. Initial menstrual cycle begun? Yes No
 - b. Date of last menstrual period ___/___/___
 - c. If (b) is more than 35 days ago, please explain:

 - d. Excessive or absent menstrual bleeding? Yes No
 - e. If (d) is Yes, please explain:

 - f. Date of last Depo-Provera shot ___/___/___
 - g. Abnormal Pap smears? Yes No
 - h. Prior cesarean section or miscarriage? Yes No

- 51. a. Are you currently pregnant? Yes No
 b. If Yes, due date ___/___/___
- 52. a. Are you (including male applicants and dependent males or females) responsible for a current pregnancy? Yes No
 b. If Yes, due date ___/___/___
- 53. Within the last 5 years, have you:
 - a. Had any medical advice, diagnosis, care, or treatment (including prescribed medications) recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement not listed above? Yes No
 - b. Had chronic cough, fatigue, diarrhea, or enlarged glands? Yes No
 - c. Been advised to have or contemplated having an operation or medical procedure not yet performed? Yes No
 - d. Been scheduled to see a health care provider? Yes No
 - e. Taken any prescription medication on a regular basis? Yes No

54. List all medications you are currently taking:

Medications	Prescribed by (name/address/telephone)	Date prescribed

(continues on page 6)

Section 5 – Questionnaire *(continued)*

Oregon Standard Health Statement
(Standard form per ORS 743.766)

55. Please provide specific details below to any questions answered Yes on the previous pages.

Question no.	Dates	Condition	Treatment	Final result

Do you have Medicare or Medicaid coverage? Yes No

Section 6 – 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

Last name

First name MI

Street address Apt./Unit #

City State ZIP

2. Effective date:

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

- 1st of the month immediately following the date the application is approved (application must be received by the 23rd of the preceding month)
- 15th of the month following the date the application is approved (application must be received by the 8th of the month of intended enrollment)
- 1st of the month plus one additional month following the date the application is approved (application must be received by the 23rd of the preceding month)
- 15th of the month plus one additional month following the date the application is approved (application must be received by the 8th of the preceding month)

3. Credit/Debit card information: Credit Debit

- Visa Discover
- MasterCard American Express

Name as it appears on card

Credit/Debit card number

Credit/Debit card security number

Expiration date

Note: Premium for enrollment 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.

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Authorization to Obtain or Release Medical Information

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* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan of the Northwest product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan of the Northwest and its affiliates), its respective agents, employees, designees, or representatives, including my KFHPNW producer, 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, HIV [human immunodeficiency virus] status, 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 also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize Kaiser Foundation Health Plan of the Northwest to disclose to my insurance producer the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the 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, or HIV/AIDS-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately 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 Kaiser Foundation Health Plan of the Northwest. A photocopy of this authorization is as valid as the original, and I and my KFHPNW producer 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		
Primary applicant/Parent or legal guardian	Today's date	Date of birth

X		
Applicant's spouse/Domestic partner	Today's date	Date of birth

X		
Applicant (age 15 or over)	Today's date	Date of birth

Signatures (required)

Important: All **Applicants age 18 or over must sign and date** above on the appropriate signature line (Primary applicant/Parent or legal guardian, Applicant's spouse/Domestic partner). **A parent or legal guardian must sign for dependents under the age of 18.** In addition, all **Applicants age 15 or over must sign and date** above on the designated signature line.

Use black ink only.

**Please read and sign in all the places noted and photocopy for your records.
We will be unable to process your application without your signature.**