**MEMBERSHIP APPLICATION FOR**

# Kaiser Permanente for Individuals and Families

**Thank you for your interest in Kaiser Permanente for Individuals and Families!** Please see the instructions inside for helpful information about filling out this application. Please keep a copy for your files. You and your authorized representative may request a copy of your completed application if needed.

**NOTE:** All applications are subject to medical underwriting. Your application must be dated within 60 days of your requested effective date. Your responses to the questions in the "Medical Information" and "Other Health-Related Information" sections may be used to determine your acceptance to the plan and the appropriate premium rate. This application may become part of your permanent medical record if your membership is approved. It may be reviewed again by you with a physician.

**Your payment must be received prior to final processing.**

Fax to 888-436-4342

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

60084210/GA/09272011

©2011 Kaiser Foundation Health Plan of Georgia, Inc.

## INSTRUCTIONS:

- Please answer all questions completely to ensure timely processing of your application.
- Use only black or blue ink.
- Completely fill in the ☐ squares. *Example:* ■
- Print clearly above the lines or inside the boxes.
- Remember to sign all the appropriate boxes on the Application Agreement (page 7). Applicants age 18 and over are required to sign the Authorization to Obtain or Release Medical Information.
- Remember to complete the Payment Options section (page 9), and include debit/credit card, check, or money order information for the first month's premium.

## 1. PERSONAL INFORMATION — PRIMARY APPLICANT

**As the oldest person applying for coverage, I am the primary applicant and hereby apply for membership in Kaiser Permanente based on the following:**

Select One: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.
Marital Status: ☐ Single ☐ Married

Last Name First Name MI Social Security # (– –)

Birth date (MM/DD/YY) Height (ft./in.) Weight (lbs.) Gender (M/F) Prior HRN*

Street Address (cannot be a P.O. Box) Apt. # City State County ZIP Code

Home Phone Work Phone E-mail Address

Is the billing address the same as the address listed above? ☐ Yes ☐ No **If No, please list the billing address below:**

Billing Street Address Apt. # or P.O. Box City State ZIP Code

Please complete the following information for each additional person applying. If more space is needed for additional applicants, please attach another application and complete just the information for those additional applicants.

**Spouse**

| Last Name | First Name | MI | Social Security # (– –) | Birth date (MM/DD/YY) | Height (ft./in.) | Weight (lbs.) | Gender (M/F) | Prior HRN* |
|---|---|---|---|---|---|---|---|---|

**Dependent 1 (D1)** Relationship - ☐ Son ☐ Daughter ☐ Other ( )

| Last Name | First Name | MI | Social Security # (– –) | Birth date (MM/DD/YY) | Height (ft./in.) | Weight (lbs.) | Gender (M/F) | Prior HRN* |
|---|---|---|---|---|---|---|---|---|

**Dependent 2 (D2)** Relationship - ☐ Son ☐ Daughter ☐ Other ( )

| Last Name | First Name | MI | Social Security # (– –) | Birth date (MM/DD/YY) | Height (ft./in.) | Weight (lbs.) | Gender (M/F) | Prior HRN* |
|---|---|---|---|---|---|---|---|---|

**Dependent 3 (D3)** Relationship - ☐ Son ☐ Daughter ☐ Other ( )

| Last Name | First Name | MI | Social Security # (– –) | Birth date (MM/DD/YY) | Height (ft./in.) | Weight (lbs.) | Gender (M/F) | Prior HRN* |
|---|---|---|---|---|---|---|---|---|

** Prior Kaiser Permanente Health Record Number (HRN), if applicable.*

**In the past five years**, has any applicant been declined, postponed, charged an additional premium, or had a waiver applied for any form of health, life or disability insurance? Check one: ☐ Yes ☐ No **If Yes, please provide the following details:**

**Applicant name:** **Reason:**

1. ______________________________

2. ______________________________

3. ______________________________

Do you, your spouse, and/or children currently have health coverage? ☐ Yes ☐ No

If yes, who is covered? (check all that apply) ☐ Primary Subscriber ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3

Provide the name of your current (or most recent) health insurance carrier and, if applicable, the date of termination.

______________________________

Carrier Name Date of Termination

## 2. PLAN SELECTION

**1.** Fill in the box next to your requested plan. (See your enrollment materials, contact your broker, or visit **buykp.org/apply** for plan choices and complete plan descriptions.)

| | | | |
|---|---|---|---|
| ☐ **Classic 1500** | ☐ **Essential 1500** | ☐ **Advantage 2500** | ☐ **HSA 5000** |
| ☐ **Classic 2500** | ☐ **Essential 3000** | ☐ **Advantage 3500** | |
| ☐ **Classic 3500** | ☐ **Essential 5000** | ☐ **Advantage 5000** | |
| ☐ **Classic 5000** | ☐ **Essential 7500** | ☐ **Advantage 7500** | |

**2.** Requested Effective Date of Coverage ☐ 1st or ☐ 15th of the month of ______________________________

The earliest your coverage will begin is the first or 15th of the month following receipt of a completed application and first month's premium. Coverage will not be back-dated.

Has any applicant ever been a Kaiser Permanente of Georgia member? ☐ Yes ☐ No **If Yes, please be sure you have written their prior Kaiser Permanente Health Record Number (HRN), if known, in the "Prior HRN" box on page 1.**

### Type of Application:

☐ New coverage ☐ Addition of a family member to an existing Kaiser Permanente member's coverage

Existing member's Health Record Number (HRN) ______________________________

If you are adding a new member to your current plan, please note:

- If the family member you are adding is the oldest member of your family on the plan, this person will become the Primary Subscriber. Your monthly premium will be based on the age of the new, older family member (Primary Subscriber), and your new contract period will be based on the effective date of this new, older member.

### What if all family members are not accepted?

Because all Applicants applying for a KPIF plan are subject to medical review, there is the possibility that one or more members of a family (except for any eligible Applicant under the age of 19 who must be accepted under applicable law) may not qualify for the plan for which they apply. We can only accept dependents under the age of 19 when a parent is approved and enrolled in a family plan. In the event that not all family members are accepted, please instruct us how to handle accepted family members.

☐ Please enroll all eligible family members.

☐ Please cancel the enrollment process for any accepted family members and return my first month's premium check.

## 3. MEDICAL INFORMATION

Answer the questions below with respect to yourself and each family member applying for coverage. **If you can answer Yes, fill in the box and explain further—for each person the Yes applies to—on the chart in Question 9.**

**1. In the last 10 years**, have you or any applicant been seen, examined, or treated for; advised that you have; been prescribed or taken any medication for; had signs or symptoms of; or had any intention to seek advice or treatment for any of the following conditions? Please mark all that apply.

- ☐ AIDS, HIV
- ☐ Sexually transmitted disease
- ☐ Hepatitis
- ☐ Hernia not repaired
- ☐ Back/neck pain or injury including herniated/ degenerative disc or scoliosis
- ☐ Broken bone/fracture (open, closed, pins, plates, or screws)
- ☐ Bone marrow transplant
- ☐ Crohn's or ulcerative colitis
- ☐ Depression or anxiety
- ☐ Mental health condition including bipolar disorder, schizophrenia, and/or manic depression
- ☐ Eating disorder, anorexia nervosa/bulimia
- ☐ Heart or valve condition
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Lung condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney/bladder condition — including kidney stones
- ☐ Liver condition or pancreas disorder
- ☐ Gallstones
- ☐ Anemia or other blood disorder
- ☐ Lupus/SLE/inflammatory condition
- ☐ Painful or irregular menses or any condition, disorder, or abnormality of the male or female reproductive organs
- ☐ Breast implants
  Saline: _______
  Silicone: _______
- ☐ Melanoma/breast/prostate/ bladder cancer
- ☐ Skin cancer
- ☐ Other cancers
- ☐ Aneurysm
- ☐ MS/ALS/Parkinson's/ Alzheimer's
- ☐ Neurologic condition
- ☐ Pacemaker or other implanted medical device
- ☐ Prostate condition
- ☐ Rheumatoid arthritis
- ☐ Seizures/headaches requiring medical treatment
- ☐ Sickle cell anemia
- ☐ Diabetes
- ☐ Stomach or intestinal problems or GI reflux
- ☐ Stroke
- ☐ Lumps (including fibrocystic breasts), masses, tumors (including uterine fibroids), polyps, or growths
- ☐ Ulcer
- ☐ Infertility
- ☐ None of the above

**2. Within the last 3 years**, have you or any applicant experienced any of the following symptoms that were unexplained or undiagnosed? Please mark all that apply.

- ☐ Fever
- ☐ Rectal bleeding
- ☐ Swollen glands
- ☐ Loss of appetite
- ☐ Chest pain
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Chronic fatigue
- ☐ Abdominal or pelvic pain
- ☐ Rash/skin problems
- ☐ Loss of consciousness
- ☐ Skin lesions
- ☐ Weight loss
- ☐ Lumps
- ☐ Weight gain
- ☐ None of the above

**3. At any time in the last 2 years,** have you or any applicant been seen in a hospital emergency room or been admitted to a hospital, outpatient surgical center, or other treatment facility?

☐ Yes ☐ No

**4. Within the last 3 years**, have you or any applicant undergone any surgery, treatment, examination, evaluation, or test for any medical or mental health condition?

☐ Yes ☐ No

**5. Within the last 3 years**, have you or any applicant been advised to have, but have not yet had, any surgery, treatment, examination, evaluation, or test for any medical or mental health condition?

☐ Yes ☐ No

**6. In the last 5 years**, have you or any applicant taken or used any illegal drugs, or any prescription drugs without a prescription?

☐ Yes ☐ No

**7. In the last 5 years**, have you or any applicant been seen or examined by a physician, health care professional, counselor, therapist, social worker, or any medically related professional for symptoms of alcohol and/or substance abuse, or participated in or been advised to participate in any program (including Alcoholics or Narcotics Anonymous) that deals with alcohol and/ or substance abuse?

☐ Yes ☐ No

**8.** Do you or any applicant have any other condition, disorder, abnormality, or symptom not listed on this application, even if not currently under treatment?

☐ Yes ☐ No

**9.** If you answered Yes or indicated any condition in **questions 1-8**, please explain below. If additional space is needed, list the information on a separate sheet of paper, sign and date it, and attach it to this application.

| Question Number | Person Treated | Purpose of visit/ Name of Illness or Disorder | Treatment/ Advice Given | Treatment Dates | | Name and Address of Health Care Provider |
|---|---|---|---|---|---|---|
| | | | | Start/End | Full Recovery? | |
| | | | | / | Yes/No | |
| | | | | / | Yes/No | |
| | | | | / | Yes/No | |
| | | | | / | Yes/No | |
| | | | | / | Yes/No | |

**10. (a) In the past year**, have you or any applicant been prescribed, taken, or been advised to take any prescription medication for any reason (including Depo-Provera or other birth control medication)?

☐ Yes ☐ No

**(b)** If Yes, please explain below. If additional space is needed, list the information on a separate sheet of paper and attach it to this application.

| Person Treated | Name of Medication | Dosage/Frequency | Treatment Dates | | Name and Address of Health Care Provider |
|---|---|---|---|---|---|
| | | | From | To | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Answer the questions below for yourself and each applicant.** (D1, D2, and D3 should correspond to the Dependents you listed under Additional Applicants in the Personal Information section.) Choose the most appropriate answer for each applicant (regardless of age) and fill in that box.

**11.** Are you an expectant parent or do you have a pending adoption?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

For all female applicants over age 11 only, please answer questions 12-15:

**12. In the last 10 years**, have you had a C-section?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**13. In the last 10 years**, have you had a delivery that resulted in a premature birth?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**14. (a)** Are you:

1. *pre-menstrual (have never menstruated)?*

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

2. *post-menopausal?*

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

3. *have you had a hysterectomy?*

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

4. *have you had a tubal ligation?*

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**14. (b)** If No to 14(a)1-4, please provide the first day, month and year of your last menstrual period:

| Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|
| MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY |

**14. (c)** Do you have regular monthly menstrual periods with 28-30 days between the first day of one period and the first day of the next period?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**15.** Are you currently breast feeding or have you stopped within the last three months?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

## 4. OTHER HEALTH-RELATED QUESTIONS

**1. (a) Within the last 6 months**, have you or any applicant consumed more than 10 alcoholic beverages per week? (One drink equals 12 oz. beer, 4 oz. glass of wine, 1 oz. hard liquor)

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**(b)** If Yes for 1 (a), write in the number of drinks consumed weekly.

| | Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|---|
| Beer | | | | | |
| Wine | | | | | |
| Hard liquor | | | | | |

**2.** Have you or any applicant **ever** been advised to reduce alcohol consumption?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**3. (a)** Have you or any applicant **ever** smoked cigarettes?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**(b)** If Yes, what is or was your or any applicant's average daily usage?

| | | | | | |
|---|---|---|---|---|---|
| 1/2 pack or less | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 1 pack | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 1 1/2 packs | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 2 or more packs | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| N/A | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**(c)** For how long?

| | | | | | |
|---|---|---|---|---|---|
| 9 years or less | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 10-14 years | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 15-19 years | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| 20-29 years | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| Over 30 years | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| N/A | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

**(d)** Have you quit?

| | | | | | |
|---|---|---|---|---|---|
| Yes | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |
| No | ☐ Self | ☐ Spouse | ☐ D1 | ☐ D2 | ☐ D3 |

If Yes, when?

| Self | Spouse | D1 | D2 | D3 |
|---|---|---|---|---|
| MM/YY | MM/YY | MM/YY | MM/YY | MM/YY |

# 5. APPLICATION AGREEMENT

I hereby apply for enrollment and I agree that the information listed is correct. Upon acceptance to the Health Plan, my enclosed check for the first month's premium will be deposited or my credit card charged, and my coverage will begin on the first or 15th day of the month as assigned by Health Plan.

**THIS AGREEMENT IS SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:**

**1.** We may rescind coverage once you or your family member is covered, if you or your family member make an intentional misrepresentation of material fact in the medical questionnaire. (See #3 for details). If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.

**2.** YOU MUST IMMEDIATELY INFORM US if your health status or current medication changes at any time before your membership with Kaiser Permanente becomes effective. Failure to inform us of such changes can void your membership. You can choose to update your application information by telephone ***(404) 364-7001*** (option 2), by fax (***404) 365-4146***, or by writing us at Kaiser Permanente for Individuals and Families; 3495 Piedmont Road, NE; Building 9; Atlanta, GA 30305. All written and fax correspondences must be signed and dated.

**3.** We may rescind your coverage or that of your family member if the Applicant (or person seeking coverage on behalf of the Applicant) performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact. "Making an intentional misrepresentation of material fact" includes intentionally providing incomplete or incorrect information about health history or status of any person applying for coverage on this Application, and such information was the basis for our decision to accept you or your family member for coverage. Rescinding coverage means completely voiding the member's contract of coverage as if no coverage had ever existed.

Once we decide to rescind coverage, we will send you a written notice at least 30 days before we actually rescind, explaining the basis for our decision and how you can appeal it. Once coverage is rescinded, you will be required to pay for any Services we may have covered. But you would also be entitled to a refund of any Premiums paid. This means that Premium refunded would be reduced by any amounts you owe for any covered Services you received.

**4.** Our decision to accept you or your family member (except for any eligible Applicant under the age of 19 who must be accepted under applicable law) for coverage will be made after we have reviewed the medical history information pertaining to you and any other Applicant disclosed in Section 4 of this application. We can only accept dependents under the age of 19 when a parent is approved and enrolled in a family plan.

**5.** Georgia residents who do not qualify for Kaiser Permanente for Individuals and Families and are not current Kaiser Foundation Health Plan members may be eligible to participate in the State of Georgia Health Insurance Assignment System, a state-sponsored guaranteed-issue health care coverage program in which Kaiser Permanente participates. For more information, call ***1-800-656-2298***. Georgia residents who do not qualify for Kaiser Permanente for Individuals and Families and who are current Kaiser Foundation Health Plan group members can choose to be considered for our conversion products, one of which is available to HIPAA-qualified individuals. If you wish to exercise that option, please contact our Customer Service Department at ***(404) 261-2590*** to obtain an application.

**I authorize the disclosure of premium billing, claim payment, and commission information to my broker of record and my spouse (if applicable) to expedite the servicing of my account.**

☐ Yes ☐ No

**IMPORTANT:** All applications must be signed and dated by Primary Applicant, Spouse (if applicable), and Dependents (age 18 or older).

Signature of Primary Applicant ____________________ Date ________

Signature of Spouse ____________________ Date ________

Signature of Dependent (age 18 or older) ____________________ Date ________

Signature of Dependent (age 18 or older) ____________________ Date ________

Signature of Dependent (age 18 or older) ____________________ Date ________

*A representative of Kaiser Permanente may contact you.*

## 6. RELEASE OF INFORMATION

**RELEASE AUTHORIZATION:** 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 me or my family member applying for, or having membership in any Kaiser Foundation Health Plan product (each, an "Applicant"), or any insurance or reinsurance company, pharmacy benefits manager, or third party administrator to give Kaiser Foundation Health Plan of Georgia, Inc., or its affiliates ("Kaiser Permanente"), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, 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) ("Medical Information") of the Applicant. However, Medical Information does not include genetic information or "Psychotherapy Notes" (as defined by 45 C.F.R. ß 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 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 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 any Kaiser Foundation Health Plan. 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 of any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's Notice of Privacy Practices.

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION**

**IMPORTANT:** All applications must be signed and dated by Primary Applicant, Spouse (if applicable), and Dependents (age 18 or older).

Signature of Primary Applicant ____________________ Date __________

Signature of Spouse ____________________ Date __________

Signature of Dependent (age 18 or older) ____________________ Date __________

Signature of Dependent (age 18 or older) ____________________ Date __________

Signature of Dependent (age 18 or older) ____________________ Date __________

## 7. PAYMENT OPTIONS

☐ **Automatic Draft Plan***

**Your most convenient and reliable option is this payment method.** Payments are automatically deducted from your checking or savings account between the first and the fifth day of each month. To enroll, simply read and fill out the section below. BE SURE TO INCLUDE A VOIDED CHECK AND YOUR FIRST MONTH'S PREMIUM.

***Note:** *If you choose the Automatic Draft Plan as your payment option, you are still required to send a check, money order, or credit card information for your first month's premium, along with a voided check. If you'd like to pay your first month's premium by credit card, enter your credit card information in the Payment by Credit Card section, and select the "First Month's Premium Only" option. The automatic draft plan takes effect in your second month of coverage.*

I hereby authorize Kaiser Foundation Health Plan of Georgia, Inc., (Health Plan) to debit my checking or savings account with the financial institution named below. If a debit will differ from that of the previous month's debit, Health Plan will notify me in writing at least seven days in advance of the change.

This authority is to remain in full force and effect until Health Plan has received written notification from me of its termination in such time and in such manner as to afford Health Plan reasonable opportunity to act on it. (Must give Health Plan 30 days.)

If an entry is erroneously initiated by Health Plan to my account, I have the right to have the amount of the entry credited to my account. However, I must give the financial institution a written notice within 15 days explaining that the entry was in error.

Bank Name

Member (Depositor) Account Number:

Bank Address

Type of account (check one)

☐ Savings Account ☐ Checking Account (*Please attach a voided check)* ☐ Other

Member Name(s) *(Please Print)*

Member Signature

Depositor Signature Date

2nd Depositor Signature (if Joint Account) Date

☐ **Payment by Debit/Credit Card**

Your credit card will be charged for your first month's premium. Also, each month's premium will be automatically charged to your credit card on or about the 20th of the month prior unless you arrange another form of payment by calling ***(404) 364-7179***. Your credit card will be charged only if you are accepted for membership.

Type of Card Credit Card Number: Expiration Date

Name As It Appears On Card Signature

Use this credit card for: ☐ All my monthly premiums ☐ First month's premium only

☐ **Payment by Monthly Invoice***

You will receive a monthly invoice from Kaiser Permanente. Payment is due on or before the first day of each month. If payment is not received by this date, you are subject to termination of membership.

***Note:** *If you choose the "Payment by Monthly Invoice option," you are still required to send a check, money order, or credit card information for your first month's premium.*

PERFORATION (DO NOT PRINT)

PERFORATION (DO NOT PRINT)

## 8. BROKER INFORMATION

**For those applicants using an insurance broker, this section should be completed by your broker after completion of this application.**

Applicant's Name

Stephen Masula

Name of Broker *(Please Print)*

2235 Sara Way

Address

Carlsbad

City

CA 92008

State Zip Code

800-915-0501 888-436-4342

Phone Fax

kaiser@ekaiserinsurance.com

E-mail

**BROKER'S STATEMENT:**

To the best of my knowledge and belief, all information and medical history supplied in this enrollment application is true and complete. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of *Kaiser Foundation Health Plan of Georgia, Inc.* or *Kaiser Permanente Insurance Company*. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance concerning incomplete or additional underwriting information.

Broker Signature

Date

Broker Number

| U | A | o | | |
|---|---|---|---|---|

General Agency Stamp (if applicable)

For Office Use Only:

Underwriter

Effective Date

60084210/GA/09272011

©2011 Kaiser Foundation Health Plan of Georgia, Inc.