Enrolling is Simple.
Just Follow These 2 Easy Steps…

Step 1

***Each family member must complete a separate application.**

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) 915-0501

Step 2

SEND THE COMPLETED APPLICATION TO:

Fax: 888-436-4342

Or Mail to:

eKaiserinsurance.com
2235 Sara Way
Carlsbad, CA 92008

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: 800-915-0501

www.eKaiserinsurance.com

KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: 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 1-800-501-1472. 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 Kaiser Permanente for Individuals and Families (KPIF) coverage as an individual or as a family. If you want coverage for your family on the same KPIF plan, please complete one application for the family. If a family member wants a different benefit plan, he or she must complete a separate application. If a family member wishes to confidentially complete an application, he or she may either request additional forms from us or use a photocopy of this application.

EXPEDITE YOUR APPLICATION – APPLY ONLINE NOW AT BUYKP.ORG/APPLY.

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 **1-866-920-6471**.

I Primary Applicant Information

Last name

First name MI

Street address Apt./Unit #

City State ZIP

( ) ❑ Day ❑ Evening
Home phone

( ) ❑ Day ❑ Evening
Work phone

Email address

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)

Primary spoken language:

❑ English ❑ Other (please specify) _____

Mailing address (if different than home address):

Street address Apt./Unit #

City State ZIP

Parent or legal guardian information
(if application is for a child-only Applicant under age 19)

Last name

First name

❑ Same address as primary applicant

Street address Apt./Unit #

City State ZIP

( )
Phone number

Date of birth Gender Relationship to Applicant

(continues on page 2)

I Primary Applicant Information *(continued)*

You may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer unless you submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the past twelve (12) months. To see if this applies to you, please answer the following questions. If left blank, your application will not be processed. **(The following questions do not apply to child-only applicants under age 19.)**

Self	Spouse	
❑ Yes ❑ No	❑ Yes ❑ No	1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?
If you answered *Yes*, please continue to the next question. If you answered *No*, please continue to "Account Information".		
❑ Yes ❑ No	❑ Yes ❑ No	2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

If the answer to both questions 1 and 2 is *Yes*, the Applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer. If the answer to question 1 is *Yes* and the answer to question 2 is *No*, the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier. If you answer *Yes* to both questions 1 and 2, you may apply for individual coverage if you pay the full premium yourself and are not reimbursed in any way by your employer.

II Account Information

Please check all boxes that apply.

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

   ❑ Yes ❑ No Medical record number and plan name of your current KPIF account _____

   _____

   If you answered *Yes*, please provide your medical record number in the space above and skip to question 5.

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

   ❑ Yes ❑ No Medical record number and plan name of your current KPIF 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

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

❑ KP Deductible HMO 1000/30/Rx	❑ KP Deductible HMO 3500/40/Rx	❑ KP 3500/0/HSA/Rx
❑ KP Deductible HMO 1500/30/Rx	❑ KP Deductible HMO 5000/40/Rx	❑ KP 4500/0/HSA/Rx
❑ KP Deductible HMO 2000/30/Rx	❑ KP Deductible HMO 6000/50	❑ KP 5500/0/HSA/Rx
❑ KP Deductible HMO 3000/30/Rx	❑ KP Deductible HMO 7500/50	

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.

(continues on page 3)

II Account Information *(continued)*

5. 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: Effective dates for applicants under the age of 19 may vary.

We will do our best to honor your desired effective date if you are approved. 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. If for some reason there is a delay in processing your application, we may need to select the next available effective date.

III Family Members to Be Covered

Complete this entire section if you are applying for KPIF coverage for yourself and your family members. If any family members have a different home address than the primary Applicant, please list that address under their names. Attach additional pages if necessary.

Spouse:

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)

Home address (if different than primary Applicant's)

Child 1:

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)

Home address (if different than primary Applicant's)

Child 2:

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)

Home address (if different than primary Applicant's)

Child 3:

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)

Home address (if different than primary Applicant's)

(continues on page 4)

III Family Members to Be Covered *(continued)*

Complete the "Primary Applicant" parts of this section if you are applying for KPIF coverage as an individual. If your application is for child-only enrollment, the child's information should be entered in the "Primary Applicant" part of this section. Complete this entire section if you are applying for yourself and your family members.

Please give the name of each family member's current or most recent primary care physician, along with his or her address and telephone number. Please also give the name of each family member's current or most recent health coverage provider.

Note: Failure to provide physician information will significantly delay processing of your application.

Primary Applicant:_____

Doctor_____

Phone_____

Date last visited_____

Address_____

City, State, ZIP_____

Health coverage provider_____ ❑ Current

or Date ended _____ / _____ /_____ **or** ❑ Not insured

Have you had health coverage within the last 63 days?

❑ Yes ❑ No

Spouse:_____

Doctor_____

Phone_____

Date last visited_____

Address_____

City, State, ZIP_____

Health coverage provider_____ ❑ Current

or Date ended _____ / _____ /_____ **or** ❑ Not insured

Has your spouse had health coverage within the last 63 days?

❑ Yes ❑ No

Child 1:_____

Doctor_____

Phone_____

Date last visited_____

Address_____

City, State, ZIP_____

Has your child had coverage within the last 63 days?
❑ Yes. Please proceed to page 5.
❑ No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)
❑ Yes. Please provide the information requested below.
❑ No. Please proceed to page 5.

Health coverage provider _____

Policy ID _____

Start date of coverage _____

End date of coverage _____

Child 2:_____

Doctor_____

Phone_____

Date last visited_____

Address_____

City, State, ZIP_____

Has your child had coverage within the last 63 days?
❑ Yes. Please proceed to page 5.
❑ No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)
❑ Yes. Please provide the information requested below.
❑ No. Please proceed to page 5.

Health coverage provider _____

Policy ID _____

Start date of coverage _____

End date of coverage _____

Child 3:_____

Doctor_____

Phone_____

Date last visited_____

Address_____

City, State, ZIP_____

Has your child had coverage within the last 63 days?
❑ Yes. Please proceed to page 5.
❑ No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)
❑ Yes. Please provide the information requested below.
❑ No. Please proceed to page 5.

Health coverage provider _____

Policy ID _____

Start date of coverage _____

End date of coverage _____

IV Kaiser Permanente for Individuals and Families Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan member. **Each Applicant for a KPIF plan must undergo medical review regardless of current or previous Kaiser Permanente coverage.** Omissions or incomplete answers regarding your or, if applicable, your family member's (or members') health history will delay processing of the application. **We may rescind coverage once the Applicant is covered if the Applicant makes an intentional misrepresentation of material fact in the medical questionnaire (see Section IX for details).**

This application becomes part of the Applicant's Kaiser Permanente record. If you need assistance completing this medical questionnaire, you may call us toll free at **1-800-501-1472**, or 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.

This is a family-level questionnaire. You must answer each question and subquestion for yourself and for everyone you are applying for. Please answer *Yes* or *No* to each question. If you are unsure whether to answer *Yes* or *No*, or if you need help completing this application, please call 1-800-501-1472. Each question that you answer *Yes* and each condition that you mark *Yes* requires an explanation. Please see the chart on pages 14–15 and provide the information requested.

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
1. **Hospitalization:** ***Within the last 12 months***, were you (or anyone you are applying for) hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2. **Office visits:** ***Within the last 12 months***, have you (or anyone you are applying for) sought advice or treatment from a medical professional's office?					
a) Physical exam	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Chiropractic visits	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Prenatal care	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Psychological counseling	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Medication management	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) A reason not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3. **Pending treatment:** ***Within the last 3 years***, have you (or anyone you are applying for) 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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(Medical questionnaire continues on page 6.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
4. **Substance abuse treatment:** ***Within the last 3 years***, have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with ***your (or his/her)*** alcohol or substance abuse?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

5. **Skin/Dermatological:** ***Within the last 3 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any skin/dermatological disorders?					
a) Acne	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Psoriasis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Burns	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Keloids requiring plastic surgery	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Cosmetic or reconstructive surgeries, revisions	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) A skin or dermatological condition not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

6. **Eyes/Ears/Nose/Throat:** ***Within the last 3 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any disorders of the eyes, ears, nose, or throat?					
a) Glaucoma	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Cataracts, cataract surgery for one or both eyes	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Crossed eyes	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Detached retina	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Macular degeneration	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Deviated septum	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Sleep apnea, chronic snoring, or unresolved insomnia	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Nasal and/or throat polyps	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) A condition of the eyes, ears, nose, or throat not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

7. **Tobacco history:** Have you (or anyone you are applying for) ever used tobacco, including snuff and chewing or other smokeless tobacco?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
a) If *Yes*, how many years?					
b) Have you stopped using tobacco products?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) If *Yes*, how many years ago did you quit?					
d) If you smoke or smoked cigarettes, pipes, cigars, and/or use or used any smokeless tobacco, please indicate quantities:					
Cigarettes: How many packs per day?					
Pipes: How many bowls per day?					
Cigars: How many cigars per day?					
Smokeless tobacco: How many packages/cans per day?					

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
8. **Illegal drugs:** ***Within the last 5 years***, have you (or anyone you are applying for) taken or used illegal drugs or prescription drugs not prescribed by a medical professional for yourself (or anyone you are applying for)?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

9. **Nervous system:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any brain, neurological, or nervous disorder?					
a) Multiple sclerosis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Autism	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Seizures treated with more than 2 medications for control	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Seizures under control with 2 or fewer medications	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Most recent seizure within the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Alzheimer's disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) A brain, neurological, or nervous disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

10. **Cardiovascular system:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any heart or cardiovascular disorders?					
a) Aneurysm	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Chest pain	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Heart attack or angina	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Congestive heart failure	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Angioplasty or coronary artery bypass	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Pacemaker	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Tachycardia or other heart arrhythmia	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Other heart disease or valve disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) Current medication(s) to control heart disease or cardiovascular symptoms	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
k) A heart or cardiovascular condition not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(Medical questionnaire continues on page 8.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
11. Respiratory system: ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any respiratory disorders?					
a) Chronic asthma treated with medications for control	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Asthma treated with prednisone therapy	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Asthma treated only with occasional use of inhalers	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Emphysema	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Chronic bronchitis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Chronic obstructive pulmonary disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Cystic fibrosis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Pulmonary tuberculosis, active or arrested	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) A lung or respiratory disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

12. Musculoskeletal system: ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any muscle or bone disorders?					
a) Back or neck pain or injury currently under treatment or controlled with medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Back or neck pain or injury for which further treatment or surgery has been recommended	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Inguinal hernia that has been repaired	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Inguinal hernia not repaired	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Umbilical hernia that has been repaired	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Umbilical hernia not repaired	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Lupus/SLE	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Chronic disabling arthritis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) Arthritis requiring daily prescription medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
k) Osteomyelitis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
l) Joint replacement surgery	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
m) Orthopedic or arthritic conditions that interfere with daily living (Examples of daily living include bathing, dressing, grooming, or walking.)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
n) Fractures (broken bones due to trauma; Examples: stress, open, or closed)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
o) A musculoskeletal condition not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
13. **Metabolic/Endocrine system:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any metabolic or endocrine (hormone) disorders?					
a) AIDS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Diabetes controlled with oral medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Diabetes controlled with insulin	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Diabetes controlled exclusively with diet and exercise	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Gestational diabetes	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) High cholesterol	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Rheumatoid arthritis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Muscular dystrophy	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Other immunological condition	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) A metabolic or endocrine disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

14. **Congenital/Developmental:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any congenital defects or developmental disorders?					
a) Down syndrome	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Cerebral palsy	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Cleft palate or lip	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Club foot	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Congenital heart defect (specify type on page 15)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Developmental delay	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Prematurity (for children up to 2 years old)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) A neurological or physical abnormality not listed above (specify on page 15)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(Medical questionnaire continues on page 10.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
15. **For males only:** ***Within the last 5 years***, have you (or any males you are applying for) been treated for, or has a medical professional advised that any of you have, any of the following:					
a) Prostate condition requiring treatment, medication, or surgery	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Genital warts	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Syphilis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Gonorrhea	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Other sexually transmitted disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Impotence or erectile dysfunction	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Infertility	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Gender identity (role) disorder	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) A male reproductive or genital disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

16. **For females only:** ***Within the last 5 years***, have you (or any females you are applying for) been treated for, or has a medical professional advised that any of you have, any of the following:					
a) Ovarian cyst operated on within the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Ovarian cyst controlled by birth control pills	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Polycystic ovary syndrome (PCOS)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Endometriosis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Chronic pelvic pain or pelvic inflammatory disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Painful or irregular menstrual cycles	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Uterine fibroids	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Silicone breast implants	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Saline breast implants	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) Infertility	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
k) Miscarriage within the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
l) Abnormal Pap test	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
n) Genital warts	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
o) Syphilis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
p) Gonorrhea	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
q) Other sexually transmitted disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
r) In vitro fertilization	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
s) Heavy periods (menstruation) causing low blood iron	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
t) Gender identity (role) disorder	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
u) A female reproductive or genital disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
17. **Digestive system:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any digestive system disorders?					
a) Ulcerative colitis or Crohn's disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Gastrointestinal bleeding	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Gastrointestinal polyps	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Unrepaired cystocele or rectocele	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Gallstones and gallbladder has not been removed	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Hepatitis A, B, C, or other, currently under treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Cirrhosis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Hepatitis A, fully recovered with no symptoms and normal liver function tests	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) Other liver condition	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
k) A digestive system disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

18. **Urinary tract:** ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any urinary tract disorders?					
a) Chronic kidney failure	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Nephrotic syndrome	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Polycystic kidneys	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Kidney failure	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Chronic kidney infections (more than 2 per year)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Kidney infection, resolved with no further treatment required	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Kidney removed with a recommendation for further treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Kidney stones, currently	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) Kidney stones within the last 24 months	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
k) Interstitial cystitis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
l) A kidney or urinary tract disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

19. **Lab results:** ***Within the last 5 years***, has a medical professional advised you (or anyone you are applying for) that any of you have any abnormal lab results?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If *Yes*, please list with patient's (or patients') name(s), name(s) of test(s), result(s), and date(s) on page 15.					

(Medical questionnaire continues on page 12.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
20. **Circulatory system:** ***Within the last 10 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any blood or circulatory system disorders?					
a) Stroke	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Transient ischemic attacks (TIA)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Hemophilia	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Thalassemia major	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Von Willebrand's disease	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Other blood disorder	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Blood pressure over 150/90	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) Currently taking 3 or more medications for hypertension	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
i) Hypertension under control with medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
j) A blood or circulatory system disorder not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

21. **Cancer:** ***Within the last 10 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any cancer?					
a) Any cancer with lymph node involvement or metastasis (spread to other tissue)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Cancer of the colon, kidney, liver, lung, ovary, or stomach	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Skin cancer that has not been removed and requires further treatment	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Melanoma	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) A cancer not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

22. **Prosthetics/Implants/Transplants:** ***Within the last 10 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
23. **Mental health:** ***Within the last 10 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any psychological or mental health disorders?					
a) Mild depression/anxiety	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Major depression or neurosis	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Situational stress, anxiety, or depression no longer requiring treatment or medication	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d) Eating disorder (anorexia nervosa or bulimia)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e) Suicide attempt	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
g) Hospitalization for a mental health condition	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
h) A psychological or mental health condition not listed above	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

24. **Prescriptions:** Are you (or anyone you are applying for) taking any prescription medications?					
If *Yes*, please list the person's name, the medication(s), the dosage, frequency, the reason the person is taking this medication, and the name/address/phone number of the prescribing medical professional on the chart on page 14.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

25. **Alcohol:** Do you (or anyone you are applying for) drink alcoholic beverages?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If *Yes*, please indicate how much you (or anyone you are applying for) drink ***per week***:					
a) Beer: How many bottles/cans per week?					
b) Wine: How many glasses per week?					
c) Hard liquor: How many drinks per week?					
On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.					

26. **Pregnancy:** Are you (or anyone you are applying for) ***currently*** pregnant or an expectant father? Or, do you (or anyone you are applying for) ***expect to be providing*** medical insurance coverage for a newborn or new adoptee within the next 9 months?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

27. **Surrogacy:** Do you (or anyone you are applying for) 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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(Medical questionnaire continues on page 14.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
28. **For females age 11 and older:**					
a) Have you ever menstruated?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b) Are your menstrual periods regular? (If you answered *No*, please explain on page 15.)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c) Are you still having regular menstrual periods? **(If you answered Yes, please indicate on page 15 the date you started your last normal menstrual period.)**	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29. **Other: *Within the last 5 years***, have you (or anyone you are applying for) been treated for, or advised by a medical professional that any of 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 chart on page 15.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Please fill in the charts below if you (or anyone you are applying for) answered *Yes* to question **24**. Attach additional pages if necessary.

Applicant's name _____ Name of prescription medication _____ Reason for taking medication _____

Dosage/frequency _____ Prescription medication start date _____ Prescription medication end date _____

Name/address/phone number of prescribing medical professional _____

Applicant's name _____ Name of prescription medication _____ Reason for taking medication _____

Dosage/frequency _____ Prescription medication start date _____ Prescription medication end date _____

Name/address/phone number of prescribing medical professional _____

Applicant's name _____ Name of prescription medication _____ Reason for taking medication _____

Dosage/frequency _____ Prescription medication start date _____ Prescription medication end date _____

Name/address/phone number of prescribing medical professional _____

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

Please fill in the charts below for each question answered *Yes* or each condition marked *Yes* in the preceding questionnaire. Attach additional pages if necessary.

Question # and letter | Family member affected | Date of diagnosis | Treatment start date | Treatment end date

Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)

Name/address/phone number of treating physician

Question # and letter | Family member affected | Date of diagnosis | Treatment start date | Treatment end date

Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)

Name/address/phone number of treating physician

Question # and letter | Family member affected | Date of diagnosis | Treatment start date | Treatment end date

Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)

Name/address/phone number of treating physician

Question # and letter | Family member affected | Date of diagnosis | Treatment start date | Treatment end date

Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)

Name/address/phone number of treating physician

V Broker/Agent Authorization

FOR APPLICANTS USING AN INSURANCE BROKER/AGENT

Broker/Agent name _____

❑ Yes ❑ No Did you, or anyone you are applying for, receive assistance from a broker/agent in filling out this application?

I understand that the broker of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan in connection with the purchase of this health plan coverage.

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

X _____

Primary Applicant/Parent or legal guardian (Use ink only.) **Today's date**

TO BE COMPLETED BY YOUR KAISER PERMANENTE–APPOINTED BROKER/AGENT

Stephen Masula
Broker/Agent name (please print)

471389
Broker/Agent ID #

General agency name (please print)

General agency ID #

2235 Sara Way
Address

Carlsbad | CA | 92008
City | State | ZIP

800-915-0501 | 888-436-4342
Phone | Fax

smasula@ekaiserinsurance.com
Email address

VI Billing Information

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 this page. 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.

In the event that you do not qualify for the standard rate (as described on page 2), we will not charge the first month's premium to the credit/debit account you provide when you are enrolling outside an open enrollment period or have a rate increase due to a health condition. Instead, we will send a paper invoice with payment due within 45 days of the date of that invoice. However, if you apply during an open enrollment period and have no rate-up, we will charge your credit/debit account for the first month's premium.

All applicants may sign up for electronic funds transfer (EFT) for the monthly premiums going forward. The EFT enrollment form will be included in the approval letter.

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

Cardholder's billing address Apt./Unit #

City State ZIP

(This page is intentionally left blank.)

The primary Applicant and spouse, if applying together, must complete, sign, and date this page for their application to be considered complete. (The following section does not apply to child-only applicants under age 19.)

VII Business Group of One Determination Form

Self	Spouse	
❑ Yes ❑ No	❑ Yes ❑ No	1. Are you or your spouse either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
❑ Yes ❑ No	❑ Yes ❑ No	2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
❑ Yes ❑ No	❑ Yes ❑ No	3. Do you or your spouse have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that is sufficient to pay for the annual premiums for the Business Group of One's health benefit plan.
❑ Yes ❑ No	❑ Yes ❑ No	4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?

Please sign below

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant _____ Date _____

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of spouse _____ Date _____ Applicant's or spouse's business _____

If you or your spouse answered *Yes* to all four questions listed above, please complete and sign the following *Business Group of One Disclosure Form*.

Please note: For Applicants who qualify as a Business Group of One, Colorado law requires that we either accept all the Applicant's family members or deny all the Applicant's family members. Therefore, if you (or your spouse, if he or she is older) answered *Yes* to all four questions, your application will be denied if any family member does not pass medical underwriting (except for any Applicant under the age of 19, who must be accepted under applicable law). We will notify each individual who did not pass review under separate cover and specify the reasons why he or she did not pass review. **(The following section does not apply to child-only applicants under age 19.)**

VIII Business Group of One Disclosure Form

Please read and sign the following disclosure required by Colorado law:

I, _____, meet the definition of a self-employed Business Group of One as attested to on the accompanying *Business Group of One Determination Form*. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group Business Group of One policy are limited to plan design, the carrier's overall cost and utilization trends *(index rate)*, my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans.

Applicant's name _____ Applicant's signature _____

Applicant's business _____ Date _____

All Applicants or legal representatives of Applicants: Please read the follow information and sign in the space(s) provided below.

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Service representative at 1-800-634-4579 before signing this application.

IX Conditions of Acceptance

You must fully answer each question in this application even though you may already be a Health Plan member. If we decide to accept you or your dependents for KPIF membership (any Applicant under the age of 19 must be accepted under applicable law), our decision would be based primarily on health information you provided in your application and would be dependent on your actual health condition being consistent with the information you provided. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician to clarify your specific condition.

If you are a present or former Health Plan member, we will review your prior health history with Kaiser Permanente before making our decision. We reserve the right to review your use of health services during your first year of membership to confirm consistency with your preenrollment health information.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or a dependent, take the time to make sure the information is accurate before submitting it to us.

Your effective date will be the date that you selected in answer to question 5 in Section II unless your application is not completed and processed in time. In that instance, if you are accepted, we will offer coverage for the next effective date permitted for the type of policy for which you are applying. Please note that if we request additional information to make your application complete and such information is not received within 30 days of our request, then we will consider your application abandoned and we will return your application to you.

We may rescind your coverage or that of your dependents 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 dependents for coverage. *Rescinding coverage* means completely voiding the member's contract of coverage as if no coverage had ever existed.

If 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. However, we will reduce your premium refund, if any, by the amount(s) you owe for any covered service(s) you received.

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**.

Primary Applicant/Parent or legal guardian

☐☐☐ – ☐☐ – ☐☐☐☐

Applicant's Social Security number

X

Applicant's signature **Today's Date**

Spouse

☐☐☐ – ☐☐ – ☐☐☐☐

Spouse's Social Security number

X

Spouse's signature **Today's Date**

IX Conditions of Acceptance *(continued)*

Dependent (age 18 and over)

Dependent's printed name

Dependent's Social Security number

X

Dependent's signature **Today's Date**

Dependent (age 18 and over)

Dependent's printed name

Dependent's Social Security number

X

Dependent's signature **Today's Date**

Dependent (age 18 and over)

Dependent's printed name

Dependent's Social Security number

X

Dependent's signature **Today's Date**

Dependent (age 17 and under)

Dependent's printed name

Dependent's Social Security number

Dependent (age 17 and under)

Dependent's printed name

Dependent's Social Security number

Dependent (age 17 and under)

Dependent's printed name

Dependent's Social Security number

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 dependents under the age of 18. **Use ink only.**

X Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

XI Authorization to Release Medical Information

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, pharmacy benefit manager, or any other medical or medically related facility, health care provider, or professional who has provided any services to me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product (each, an *Applicant*), or any entity that compiles *Medical Information* from any of these individuals or entities to give Kaiser Foundation Health Plan of Colorado, 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. § 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 Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any dependents 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 any Medical Information, 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 on the date that the Applicant signs the application and will remain in effect for a period of twenty-four (24) months. 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 _____

Primary Applicant/Parent or legal guardian (signing on behalf of self and all dependents under the age of 12) — **Today's date**

X _____

Applicant's spouse — **Today's date**

X _____

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

X _____

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

X _____

Applicant/Dependent (age 12 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 dependents under the age of 18. In addition, all Applicants age 12 or over must sign and date above on the appropriate signature line. **Use ink only.**

XII Kaiser Foundation Health Plan Arbitration Agreement

Except for: (1) claims filed in Small Claims Court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the *Medicare Managed Care Manual*, your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians ("respondent[s]"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Note: Any intentional misrepresentation of your current health status may void your coverage or the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

X _____

Primary Applicant/Parent or legal guardian (signing on behalf of self and all dependents under the age of 18) — **Today's date**

X _____

Applicant's spouse — **Today's date**

X _____

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

X _____

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

X _____

Applicant/Dependent (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 dependents under the age of 18. **Use ink only.**

XIII Information about CoverColorado

Colorado residents who do not qualify for Kaiser Permanente for Individuals and Families plans may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. CoverColorado does not impose pre-existing conditions or limitations on coverage. For information about CoverColorado, please contact that agency directly at:

CoverColorado
425 S. Cherry St., Suite 160
Glendale, CO 80246
(303) 863-1960
covercolorado.org
covercolorado@covercolorado.org

For office use only:	PH 0 CSC 0	Area No. _____
Medical Record No. _____	Family Account No. _____	Purchaser No. _____
Date Received _____	Status: 0 Approved 0 Denied	Effective Date _____

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KAISER PERMANENTE®

FORM OF AFFIDAVIT

This form is for applicants with an employer who has 50 or fewer employees and will be paying for or reimbursing the applicant for all or part of his or her insurance premiums.

Applicant information:

Last name

First name MI

Street address Apt./Unit #

City State ZIP

( )
Home phone number

( )
Work phone number

Date of birth

Have your employer (or his or her representative) sign this affidavit to certify that your employer has not had a small group health benefit plan providing coverage to any employee in the past 12 months.

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

Or send it by secure fax to **1-866-920-6471**.

The undersigned officer or principal of the employer certifies that:

1. The employer is a small business employer as defined in § 10-16-102(40), C.R.S., with 50 or fewer eligible employees.
2. The employer has not had in place a small group health benefit plan for the 12 months prior to the execution of this affidavit.
3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Employer information:

Company

Street address

City State ZIP

X

Signature **Date**

Printed name **Position**