Application for health coverage

Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA).

- If you want coverage for your family on the same KFHPGA plan, please fill out 1 application for the family.
- If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for KFHPGA coverage, you must live in our Georgia service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, do not complete this application. You must apply for coverage through the Health Insurance Marketplace at **healthcare.gov**.

Apply faster online

- You can apply faster online at **buykp.org/apply**.
- If you'd like to email us, please apply online and set up a secure email account.

Things to remember

- Please answer all questions and type or print using ink only.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you are applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period guide and include any required documentation so your application will be complete. Your effective date may be different than the dates listed above if you apply because of a special enrollment period.
- To avoid being billed twice, if you are enrolled in a plan through the Health Insurance Marketplace, you must cancel your current plan on or before the effective date of your new plan.
- **Make sure your application is complete, signed, and includes your 1st month's premium payment. If your application is incomplete or does not include your 1st month's payment, it may be canceled.**
- Send your complete, signed application and 1st month's premium payment by mail to:

  Kaiser Permanente Individuals and Families Plans
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to:
  Individuals and Families Plans: **1-866-816-5139**

  Note: Checks must be mailed and cannot be faxed.

Need help?

- For help completing this application, please call **1-800-914-5521.** For TTY for the deaf, hard of hearing, or speech impaired, call **711.**
- **We will provide language assistance at no cost to you.**
- If you are working with a broker, please call him or her for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305.

KAISER PERMANENTE®

Primary applicant _____

Step 1: Tell Us When You're Applying

Select 1 option:
- ○ Open enrollment
- ○ A special enrollment period

If you are applying during a special enrollment period, please write the date of your triggering event.

_____/_____/_____

If you selected "A special enrollment period," choose the triggering event:
- ○ Loss of health care coverage
- ○ Gaining or becoming a dependent through marriage
- ○ Gaining a dependent through the birth of a child, adoption, or foster care
- ○ Court order to cover a child
- ○ Losing a dependent through divorce or legal separation
- ○ Death of the subscriber or a dependent
- ○ Permanent relocation
- ○ Release from incarceration
- ○ Change in eligibility for federal financial assistance through healthcare.gov*
- ○ Change in eligibility for employer health coverage
- ○ Determination by healthcare.gov

*If you will be getting federal financial assistance, do not use this form. We can help you apply through healthcare.gov.

Step 2: Choose Your Health Plan

Choose 1 KFHPGA health plan. If any family members are applying for different health plans, please submit a separate application form for each plan.

Bronze	Silver	Gold
○ KP GA Bronze 4000/20	○ KP GA Silver 1500/30	○ KP GA Gold 500/20
○ KP GA Bronze 5000/50	○ KP GA Silver 2500/30	○ KP GA Gold 1000/20
○ KP GA Bronze 6000/40%/HSA	○ KP GA Silver 2750/20%/HSA	○ KP GA Gold 1500/20

Catastrophic Plan

We also offer a Catastrophic plan, a high-deductible option for applicants under 30 and certain people 30 and older. If you or any family members are 30 or older, you may apply for this plan only if you submit with your completed application a certificate of exemption from the Health Insurance Marketplace that indicates lack of affordable coverage or financial hardship. A certificate of exemption is required for each applicant 30 or older.

○ KP GA Catastrophic 6850/0

For information describing the benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Evidence of Coverage* for a particular plan, please call **1-800-634-4579** or contact your broker.

Step 3: Enter Your Information

Primary Applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under age 18, the child is the primary applicant.

First name		Middle name	Last name
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Health record number (if any)

Home address (no P.O. boxes, please)			Apt. number
City	State	ZIP	County

Mailing address (if different from home address)			Apt. number
City	State	ZIP	County

Main phone	Other phone	Preferred language spoken (if not English)	Preferred language read (if not English)
( ) –	( ) –		

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Spouse/Domestic Partner to Be Covered

A domestic partner is a person registered and legally recognized as your domestic partner by Georgia or another state.

First name		Middle name	Last name
Gender ○ M ○ F	Social Security number	Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

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Step 3: Enter Your Information *(continued)*

Dependents to Be Covered

If you have more than 5 dependents to be covered, attach another application and complete just the information for those applicants.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

First name	Middle name	Last name	Relationship to primary applicant
Gender ○ M ○ F / Social Security number		Date of birth (mm/dd/yyyy)	Health record number (if any)

FOR ALL APPLICANTS 21 OR OLDER:
Have you used tobacco an average of at least 4 times per week in the past 6 months (except for religious or ceremonial purposes)? ○ **Yes** ○ **No**
Tobacco products include cigarettes, cigars, and chewing or other smokeless tobacco. Regular tobacco users may pay different premiums.

Step 4: Parent or Legal Guardian (if the primary applicant is a child under age 18)

First name	Middle name	Last name	Gender ○ M ○ F	Date of birth (mm/dd/yyyy)

Same address as primary applicant? ○ Yes ○ No If no, fill in your address below.

Billing address	Apt. number

City	State	ZIP	County

Main phone	Other phone	Preferred language spoken (if not English)	Preferred language read (if not English)
( ) –	( ) –		

Step 5: Choose an Authorized Representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application. This person is called an *authorized representative*.

First name	Middle name	Last name

Street address	Apt. number

City	State	ZIP	County

Phone
( ) –

By signing, you have appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

Primary applicant or parent or legal guardian if the primary applicant is a child under age 18	Date (mm/dd/yyyy)
X	

Step 6: Sign the Application Agreement

Important: All applicants and dependents 18 or older must read, sign, and date below. If the primary applicant is a child under age 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. If signatures are missing, we cannot continue processing the application.

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.

The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call **1-800-634-4579.**

Primary applicant (parent or legal guardian for children under age 18) X	**Date (mm/dd/yyyy)**
Spouse/Domestic partner X	**Date (mm/dd/yyyy)**
Dependent (18 or older) X	**Date (mm/dd/yyyy)**
Dependent (18 or older) X	**Date (mm/dd/yyyy)**
Dependent (18 or older) X	**Date (mm/dd/yyyy)**
Dependent (18 or older) X	**Date (mm/dd/yyyy)**
Dependent (18 or older) X	**Date (mm/dd/yyyy)**

Step 7: Enter Details for 1st Month's Premium Payment

These billing questions are processed securely and separately from the rest of your application.

Your application must be accompanied by payment for your 1st month's premium. If your payment or payment information is missing or incomplete, your application may be canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Don't send cash through the mail.

Billing Information

Complete the following information for the person responsible for making the payment. This is the primary applicant unless someone else is identified in Step 4 as the person responsible for making the payment.

First name	Middle name	Last name	Amount of your 1st month's premium
			$

Billing address	Apt. number

City	State	ZIP	County

Payment Options

Check your preferred payment option below and complete that section.

◯ **CREDIT/DEBIT CARD** If you are paying by credit or debit card, please complete the following information:

Credit/debit card information: ◯ Credit ◯ Debit	◯ Visa ◯ MasterCard ◯ Discover ◯ American Express
Cardholder's name as it appears on card	
Credit/debit card number	Expiration date (mm/yyyy)
Cardholder's signature X	Date (mm/dd/yyyy)

◯ **ELECTRONIC PAYMENT**

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ◯ Checking account ◯ Savings account	Bank name
Routing number	Account number

(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)

Account holder's full name (print)	Account holder's signature X

◯ **CHECK** ◯ **MONEY ORDER**

If you are paying by check or money order:

- Make the check or money order out to Kaiser Permanente Individuals and Families Plans.
- Write the name of the primary applicant on the check.
- Mail with this application to the address listed on page 1.

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Primary applicant _____

Automatic Monthly Payments

For your convenience, if you paid your 1st month's premium by credit card or electronic payment, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

Billing Information

Same as 1st month's premium? ○ Yes ○ No If no, complete the following information for the person responsible for making the payment.

First name	Middle name	Last name

Billing address	Apt. number

City	State	ZIP

Payment Options

I understand that if I have chosen the option to set up a repeating premium payment schedule and later wish to cancel or update it, I must do either of the following:

1. Go to **kp.org/payonline** and follow instructions to create a profile and cancel or update my repeating payment schedule.
2. Call the KFHP Member Service Call Center at **1-866-278-9502** for assistance from a customer service representative to cancel or update my repeating payment schedule.

○ CHARGE MY CREDIT CARD

By filling out this section, you are requesting that your premiums be automatically charged to your credit card on your due date and agreeing to the terms outlined above.

Credit card information: ○ Visa ○ MasterCard ○ Discover ○ American Express

Cardholder's name as it appears on card	
Credit card number	**Expiration date (mm/yyyy)**
Cardholder's signature X	**Date (mm/dd/yyyy)**

○ DEDUCT FROM MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on your due date and agreeing to the terms outlined above.

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ○ Checking account ○ Savings account	**Bank name**
Routing number	**Account number**

(At the bottom of your check, you will see 3 groups of numbers. The 1st group of numbers is your routing number; the 2nd group is your account number. Checking and savings account routing numbers are different.)

Account holder's full name (print)	Account holder's signature X

○ I AM NOT INTERESTED IN THE AUTOMATIC PAYMENT OPTION

Enter Information for Your Agent/Broker/KPIF Representative

(if you have one)

I (the applicant) authorize the agent/broker/KPIF representative listed below to share enrollment, disenrollment, and summary plan information specific to this application with Kaiser Foundation Health Plan of Georgia, Inc. I understand that the person listed here may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of Georgia, Inc., in connection with the purchase of this health plan coverage.

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

To be completed by your agent/broker/KPIF representative after completion of this application:

I (agent/broker/KPIF representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the *Evidence of Coverage* except through written materials furnished by Kaiser Foundation Health Plan of Georgia, Inc. The applicant has been informed that the effective date of coverage is assigned by Kaiser Foundation Health Plan of Georgia, Inc. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agent/broker/KPIF representative (first, middle, last) (please print)		Agent/broker/KPIF representative identification number
Agency name		
Phone	Fax	Email address