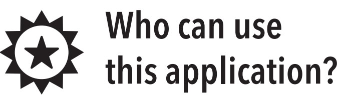
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St., Rockville, MD 20852

Application for health coverage

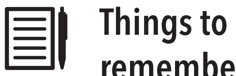
Kaiser Permanente Individual and Family Plans, Maryland



Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Permanente for Individuals and Families (KPIF).

- If you want coverage for your family on the same KPIF 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 KPIF coverage, you must live in our Maryland service area.
- To be eligible for KPIF coverage, you can't be entitled to Medicare Part A or enrolled in Medicare Part B.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Maryland Health Connection at **marylandhealthconnection.gov**.
- If you're already a member, don't use this form. To change your plan, call **1-866-410-7536.**



Things to remember

- You can apply faster online at **buykp.org/apply**.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- 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're applying during a special enrollment period, you can find instructions at **kp.org/specialenrollment** or call **1-800-494-5314.** Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- Remember, this new enrollment will not end other coverage through Maryland Health Connection or Kaiser Permanente. Don't want 2 plans? Be sure to end your other plan the day before your new plan starts to avoid paying 2 premiums and having a gap in your coverage.
- **If your application is incomplete, not signed, doesn't include your first month's payment, or doesn't include required special enrollment period documentation, it may be canceled.**
- Send your complete, signed application and first month's premium payment by mail to:

  Employer Services Dept./KPIF 5W
  Kaiser Permanente for Individuals and Families
  2101 East Jefferson St.
  Rockville, MD 20852-9995

  Or send it by secure fax to: **1-855-414-2796**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-914-5521.** For TTY, call **711.**
- **We'll provide language assistance at no cost to you.**
- If you're working with an agent or a broker, please call him or her for assistance.

Primary applicant

6 0 5 8 5 6 1 7 8

STEP 1: Check your eligibility

Are you or anyone else in your family either entitled to Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No
If you selected "Yes," those of you who are entitled to Medicare Part A or enrolled in Medicare Part B can't enroll in an individual and family plan. Please visit **kp.org/medicare** to learn more about your Medicare plan options or apply for coverage.

STEP 2: Tell us when you're applying

Select 1 option:

- ☐ Open enrollment
- ☐ A special enrollment period

If you're applying during a special enrollment period, please write the date of your triggering event (or qualifying life event).

Date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

For more information on minimum essential coverage and qualifying triggering events, please visit **kp.org/specialenrollment** or call **1-800-494-5314.**

If you selected "A special enrollment period," choose the triggering event:

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Losing a dependent through divorce or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Change in eligibility for federal financial assistance through Maryland Health Connection†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Maryland Health Connection

*If your triggering event is loss of Kaiser Permanente coverage, we may review your prior membership records to establish eligibility.
†If you'll be getting federal financial assistance, don't use this form. We can help you apply at **marylandhealthconnection.gov**.

STEP 3: Choose your health plan

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

Bronze	Silver	Gold	Platinum
☐ KP MD Bronze 6500/50/Dental	☐ KP MD Silver 6000/35/Dental	☐ KP MD Gold 1500/20/Dental	☐ KP MD Platinum 0/5/Dental
☐ KP MD Bronze 6200/20%/HSA/Dental	☐ KP MD Silver 3000/30/Dental	☐ KP MD Gold 1000/20/Dental	
☐ KP MD Bronze 5500/50/Dental	☐ KP MD Silver 2750/20%/HSA/Dental	☐ KP MD Gold 0/20/Dental	
	☐ KP MD Silver 2000/30/Dental		

Catastrophic plan

To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

- ☐ KP MD Catastrophic 7350/0/Dental

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement and Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-777-7902,** or contact your agent or broker.

STEP 4: Choose your optional adult dental plan

Pediatric dental coverage is included in your health plan for members until the end of the month in which they turn 19. Preventive adult dental is also included for members 19 and older. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

- ☐ Yes. I'd like to enroll in the optional adult dental plan.
- ☐ No. I'm not interested in the optional adult dental coverage.

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Primary applicant

STEP 5: 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 18, the child is the primary applicant.

Check 1 of the following to indicate the level of coverage you'd like: ☐ Adult(s) ☐ Adult(s) and child(ren) ☐ Child(ren)

First name

Social Security number (if any) ___-__-____

Last name

Date of birth (mm/dd/yyyy) __/__/____

MI

Former medical record number (if any) -

State (if any)

Gender: ☐ Male ☐ Female

Phone ___-___-____

Home address (no P.O. boxes, please)

City

State

ZIP code

County

Billing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Parent or legal guardian

(if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if any) ___-__-____

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy) __/__/____

Spouse/domestic partner to be covered

A domestic partner is a person legally recognized as your domestic partner by Maryland.

First name

MI

Choose one: ☐ Spouse ☐ Domestic partner

Last name

Social Security number (if any) ___-__-____

Former medical record number (if any) -

State (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy) __/__/____

(continues)

Primary applicant

STEP 5: Enter your information *(continued)*

Dependents to be covered

If you have more than 4 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any) -

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

2 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any) -

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

3 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any) -

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

4 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any) -

State (if any)

Gender: Male Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Primary applicant

STEP 6: 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 only. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've 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.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

STEP 7: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 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. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application.

- I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.
- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 301-468-6000 or 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

X

Date (mm/dd/yyyy)

Spouse/domestic partner

X

Date (mm/dd/yyyy)

Dependent (18 and older)

X

Date (mm/dd/yyyy)

Dependent (18 and older)

X

Date (mm/dd/yyyy)

Dependent (18 and older)

Primary applicant

STEP 8: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options

☐ **Credit card** ☐ **Debit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

/

X

Cardholder's signature

Date (mm/dd/yyyy)

/ /

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's premium amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

/ /

☐ **Check** ☐ **Money order**

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

Primary applicant

Automatic monthly payments

This **optional** service allows you to automatically pay your monthly premiums electronically on the last day of the month (unless it falls on a weekend or holiday). If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **301-468-6000 or 1-800-777-7902.**

Billing information

Is this information the same as your first month's payment details? ☐ Yes ☐ No **If no, please fill out this section.**

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Payment options

Debit cards can't be used for automatic monthly payments.

☐ **Credit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

/

X

Cardholder's signature

Date (mm/dd/yyyy)

/ /

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's premium amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

/ /

Primary applicant

For applicants using an agent/broker/KPIF representative

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. A Kaiser Permanente representative includes any agent/broker/KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/Broker/KPIF representative first name

MI

Last name

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.

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

I (the applicant) authorize the insurance agent/broker/KPIF representative listed below to share enrollment and disenrollment information specific to this application with Kaiser Permanente.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy) / /

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

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

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation. ☐ Yes ☐ No

X

Agent/Broker/KPIF representative

Date (mm/dd/yyyy) / /

Agent/Broker (first, middle, last) (please print)

Address

City

State

ZIP code

National producer number (NPN)

Phone - -

Fax - -

Kaiser Permanente–appointed broker ID

Broker firm name

General agency name

Broker firm federal tax ID number

General agency's federal tax ID number

Email address

KPIF representative (first, middle, last) (please print)

KPIF representative's license number

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ̀ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 **(Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).