KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?	You may use this application to apply for a Kaiser Foundation Health Plan of the Northwest (KFHPNW) plan. • If you want coverage for your family on the same KFHPNW plan, please fill out one application for the family. If someone in your family wants a different health or dental plan, they must complete a separate application. • To be eligible for KFHPNW coverage, you must live in our Oregon service area.
Who should not use this application?	• If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KFHPNW coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage. • If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You can apply for coverage at **buykp.org**. • To make changes to your existing KFHPNW account, call **1-800-813-2000** (TTY **711**).
Things to remember	• If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org**. • If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for instructions. • 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. • Remember, enrolling in a new plan won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts. If your qualifying life event is loss of Kaiser Permanente coverage, we may review your membership records to check when and why you lost coverage. • **To make sure your application is processed in time and isn't canceled,** please return every page of the application, completed, with all the required signatures, and proof of your qualifying life event. All fields are required if information is available. Providing your phone number and email will make it easier for us to reach out, if needed, to process your application. Send these materials by mail to: Kaiser Permanente for Individuals and Families P.O. Box 23127 San Diego, CA 92193-9921 Or send it by secure fax to: **1-855-355-5334** Note: Checks must be mailed and can't be faxed.
Need help?	• For help with completing this application, please call **1-800-494-5314** (TTY **711**). • **We'll provide language assistance at no cost to you.** • If you're working with a producer, please call them for assistance.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232.

Primary applicant

STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

Change in health coverage

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums

Change in household

- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care

  Note: In this case, you also need to choose between 2 effective date options:

  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Child support order or other court order to cover a dependent

  Note: In this case, you also need to choose between 2 effective date options:

  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Domestic violence or spousal abandonment occurring within the household

Change in residence

- ☐ Permanent relocation with access to new plans

Other qualifying life events

- ☐ Determination by the Oregon Health Insurance Marketplace of exceptional circumstances

Please write the date when your qualifying life event occurred. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Primary applicant

STEP 2: Choose your health plan

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

Bronze	Silver	Gold
☐ KP OR Standard Bronze Plan	☐ KP OR Silver 5500	☐ KP OR Standard Gold Plan
☐ KP OR Bronze HSA 7100	☐ KP OR Silver 4000 X	☐ KP OR Gold HSA 2100
☐ KP OR Bronze 6000	☐ KP OR Silver HSA 3600	☐ KP OR Gold 1750
	☐ KP OR Silver 3000 X	☐ KP OR Gold 0
	☐ KP OR Silver 1000	

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 *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-813-2000** (TTY **711**), or contact your producer.

STEP 3: Choose your dental plan

If you enroll in an Individuals and Families health plan, then by law you must also enroll in a separate pediatric dental plan with us or with another company, even if you are over 18. (Our family dental plans include the required pediatric dental benefits.)

- Everyone on this application must apply for the same dental plan.
- If anyone in your family wants to apply for a different dental plan, please submit a separate application.

Family dental plans

I'd like dental coverage for:	Please select your dental plan.
☐ Adults only (ages 19 and older)	☐ KP OR Family Dental - $1000/$50 Ded
☐ Adults and children	☐ KP OR Family Dental - $1000
☐ Children only (ages 18 and younger)	☐ KP OR Family Dental - $100 Ded

STEP 4: Enter your information (All fields are required, if available)

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.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Home address (no P.O. boxes)

City

State | ZIP code | County | Primary phone (mobile phone, if available)

Email address

Mailing address ☐ Check if same as home address

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes
If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

Primary applicant

Parent or legal guardian

Please complete this section if the primary applicant is a child under 18. The parent or legal guardian must be 18 or older.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Preferred language spoken (if not English)

Preferred language read (if not English)

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by the state of Oregon.

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Former medical record number (if any) | State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Primary phone (mobile phone, if available)

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Primary applicant

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application. Provide phone and email for dependents aged 18 and over only.

1 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Relationship to primary applicant | Primary phone (mobile phone, if available)

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

2 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Relationship to primary applicant | Primary phone (mobile phone, if available)

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Primary applicant

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application. Provide phone and email for dependents aged 18 and over only.

3 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any)

Relationship to primary applicant | Primary phone (mobile phone, if available)

Email address

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 only. This person is called an authorized representative.

First name | MI

Last name | Primary phone (mobile phone, if available)

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)

Primary applicant

STEP 6: Sign the application agreement

Important: The primary applicant must read, sign, and date below. If the primary applicant is a child under 18, then their 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 your signature is missing, we will cancel the application. To be eligible for KFHPNW coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- If I worked with a producer, I permit KFHPNW to share the enrollment and disenrollment information listed on this application with them. I understand that the producer or Kaiser Permanente representative may get financial and/or nonfinancial payments from KFHPNW because they assisted me with this application.
- I understand that it may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and the cancellation of your policy. I acknowledge by my signature that the information I have supplied on this form is true and correct.
- If I'm not purchasing a pediatric dental plan, I attest that I and other dependents on the application have obtained and will maintain a pediatric dental plan certified by the Oregon Health Insurance Marketplace.
- By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information visit **healthy.kaiserpermanente.org/termsconditions**.

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

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

Primary applicant

STEP 7: Enter first month's payment details

If you do not send complete payment information or payment with your application, you will receive an invoice. You must pay your first month's premium by the due date noted on the invoice or your application will be canceled and you will not have coverage.

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options (choose one) ☐ Electronic payment ☐ Check ☐ Money order ☐ Credit card ☐ Debit card

If electronic payment, select account type: ☐ 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 payment 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)

If check or money order

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

To pay with a credit or debit card, please fill out the section below.

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)

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-866-291-4010** (TTY **711**).

Do you want to sign up for automatic monthly payments?

- ☐ Yes
  - ☐ I want to enter a new payment method here. (Please fill out this page.)
  - ☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)
- ☐ No, I don't want automatic monthly payments. (Skip this page.)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Automatic payment options (choose one) ☐ Electronic payment ☐ Credit card (debit cards can't be used)

If electronic payment, select account type: ☐ Checking account ☐ Savings account

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

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)

To pay with a credit card, please fill out the section below.

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)

Primary applicant

For applicants using a producer or Kaiser Permanente representative

If a producer or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The producer may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Our standard compensation is $20 for medical plans and $2.50 for dental plans, per member per month, plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

Note: Premiums are the same whether or not you use a producer or Kaiser Permanente representative.

To be completed by your producer or representative after you complete this application:

Agency name

Agency ID number

Producer or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Primary phone (mobile phone, if available)

Fax

Email address

I (the producer/Kaiser Permanente 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 KFHPNW. The applicant has been informed that the effective date of coverage is assigned by KFHPNW. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

☐ Yes ☐ No

X

Producer or Kaiser Permanente representative

Date (mm/dd/yyyy)

Nondiscrimination notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides 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 Member Services at **1-800-813-2000** (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, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

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
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

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Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية(Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（TTY：**711**）。

فارسی(Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** (TTY (تلفن متنی): **711**) تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY: **711**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັ້ງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

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