Kaiser Permanente
Application Checklist

_____ **1. Completed application written in the oldest applicants name.**

_____ **2. First month's premium (check or credit card. Premium is based upon the oldest family member's age (check made payable to Kaiser Permanente)**

_____ **3. Voided check (optional - for automatic bank draft only)**

_____ **4. All applicants age 18 yrs. and over must sign and date application.**

_____ **5. <u>All</u> questions must be answered. Any changes must be initialed.**

If paying first payment by credit card, fax your completed application to 770-396-4318. If paying by check, Mail application and check (payable to Kaiser Permanente) to:

Insurance Now
5 Dunwoody Park, Suite 113
Atlanta, GA 30338

Please call us with any questions @ (770) 396-9517 or e-mail us at holly@insurance-now.com

Thank you for your business. We look forward to serving you – *Holly and Chris*

INSTRUCTIONS:

- **Please answer all questions completely to ensure timely processing of your application.**
- Use only black or blue ink.
- Completely fill in the ☐ squares. *Example:* ■
- Print clearly above the lines or inside the boxes.
- Remember to sign all the appropriate boxes on the Application Agreement (page 8). Applicants age 18 and over are required to sign the Authorization to Obtain or Release Medical Information.
- Remember to complete the Payment Options section (page 11), and include debit/credit card, check, or money order information for the first month's premium.

NOTE: Males age 50+ who have not had medical coverage in the last 6 months are required to submit complete physical exam results dated within the previous 24 months.

NOTE: Females age 40+ must have had a pelvic/pap exam and mammogram within 24 months of applying for coverage. This information, along with the name and telephone number of the provider must be provided in question 9.

1. PERSONAL INFORMATION — PRIMARY APPLICANT

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

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

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

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

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

Home Phone | Work Phone | Email Address

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

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

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

Spouse

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

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

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

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

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

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

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

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

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

Applicant name: **Reason:**

1. _____

2. _____

3. _____

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

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

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

_____

Carrier Name Date of Termination

2. PLAN SELECTION

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

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

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

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

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

Type of Application:

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

Existing member's Health Record Number (HRN) _____

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

What if all family members are not accepted?

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

☐ Please enroll all eligible family members.

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

3. MEDICAL INFORMATION

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

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

A. BLOOD, CIRCULATORY SYSTEM

- ☐ Anemia, Iron deficiency, Sickle cell trait
- ☐ Deep vein thrombosis, other clotting disorders or coagulation defects
- ☐ Hemophilia, Sickle cell anemia, Thalassemia major, Von Willebrand's disease
- ☐ Phlebitis
- ☐ Stroke, Transient ischemic attacks (TIA)
- ☐ Other blood or circulatory system disorder not listed
- ☐ NONE OF THE ABOVE

B. BRAIN, NEUROLOGICAL, NERVOUS

- ☐ Alzheimer's disease
- ☐ Attention deficit disorder
- ☐ Attention deficit hyperactivity disorder
- ☐ Autism spectrum disorder
- ☐ Multiple sclerosis, Muscular dystrophy
- ☐ Seizures controlled with no medication
- ☐ Seizures, most recent seizure within the last 12 months
- ☐ Seizures treated with one or more medication for control
- ☐ Other brain, neurological, or nervous disorder not listed
- ☐ NONE OF THE ABOVE

C. BREAST DISORDER

- ☐ Fibrocystic breast disease
- ☐ Simple cysts completely resolved
- ☐ Tumor, mass, nodule not surgically removed
- ☐ Other breast disorder not listed
- ☐ NONE OF THE ABOVE

D. CANCER

- ☐ Internal cancers
- ☐ Skin cancer other than melanoma that has been completely removed and no further treatment recommended
- ☐ Other cancers not listed
- ☐ NONE OF THE ABOVE

E. CONGENITAL DEFECT, DEVELOPMENTAL DISORDER

- ☐ Cerebral palsy
- ☐ Chromosome abnormality
- ☐ Club foot, Cleft palate or lip
- ☐ Congenital heart defect (specify type in question 9)
- ☐ Down's syndrome
- ☐ Other congenital defects or developmental disorder not listed
- ☐ NONE OF THE ABOVE

F. DIGESTIVE SYSTEM

- ☐ Cirrhosis
- ☐ Gallstones which gallbladder has not been removed
- ☐ Gastroesophogeal reflux disease (GERD)
- ☐ Gastrointestinal bleeding
- ☐ Hepatitis A fully recovered with no symptoms and normal liver function tests
- ☐ Hepatitis A, B, C or other currently under treatment
- ☐ Hepatitis B, C or other, chronic and ongoing (including carrier status)
- ☐ Ulcerative colitis, Crohn's disease
- ☐ Unrepaired cystocele or rectocele
- ☐ Untreated gastrointestinal/colon polyps
- ☐ Other liver conditions
- ☐ Other digestive system disorder not listed
- ☐ NONE OF THE ABOVE

G. EYES, EARS, NOSE, THROAT

- ☐ Cataracts
- ☐ Detached retina
- ☐ Deviated septum with surgery recommended
- ☐ Glaucoma
- ☐ Hearing impairment requiring surgery
- ☐ Macular degeneration
- ☐ Nasal and/or throat polyps
- ☐ Sleep apnea, Chronic snoring, or Unresolved insomnia
- ☐ Other conditions of the eyes, ears, nose, or throat not listed
- ☐ NONE OF THE ABOVE

H. HEART DISEASE, VALVE DISORDER

- ☐ Aneurysm, Heart attack or Angina, Congestive heart failure, Angioplasty, Coronary artery bypass, Pacemaker, Tachycardia
- ☐ Chest pain
- ☐ Heart arrhythmia
- ☐ Heart murmur or Mitral valve prolapse currently treated with medication or recommendation for ongoing treatment
- ☐ Other heart disease or valve disorder not listed
- ☐ NONE OF THE ABOVE

I. HIGH BLOOD PRESSURE, HIGH CHOLESTEROL

- ☐ High blood pressure with average readings of 140/90 and under, controlled by diet
- ☐ High blood pressure with average readings of 140/90 and under, controlled with 2 or more medications
- ☐ High blood pressure with average reading over 140/90
- ☐ High blood pressure with kidney disease
- ☐ High cholesterol with reading of 200 or less, controlled by medication
- ☐ High cholesterol with average readings between 201 and 239
- ☐ High cholesterol with average readings 240 and greater
- ☐ NONE OF THE ABOVE

J. KIDNEY, URINARY TRACT

- ☐ Chronic kidney failure, Nephrotic syndrome, Polycystic kidneys, Kidney failure, Kidney removed with recommendation for further treatment
- ☐ Interstitial cystitis
- ☐ Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests
- ☐ Kidney stones present
- ☐ Kidney stones within the last 12 months
- ☐ Other kidney or urinary tract disorder not listed
- ☐ NONE OF THE ABOVE

K. LUNG, RESPIRATORY

- ☐ Asthma treated with daily medications for control
- ☐ Asthma treated with occasional use of inhalers, no emergency room visits within last 12 months
- ☐ Asthma treated with prednisone therapy, asthma history of 3 or more emergency room or hospital visits within the last 12 months
- ☐ Emphysema, Chronic obstructive pulmonary disease (COPD)
- ☐ Pulmonary tuberculosis - active or arrested, Cystic fibrosis
- ☐ Other lung or respiratory disorder not listed
- ☐ NONE OF THE ABOVE

L. MENTAL, BEHAVIORAL HEALTH

- ☐ Eating disorder (Anorexia nervosa or Bulimia)
- ☐ Hospitalization for any mental health condition and/or suicide attempt
- ☐ Mild depression, Anxiety, Situational stress no longer requiring medication or counseling
- ☐ Mild depression, Anxiety with counseling
- ☐ Psychosis, Senile dementia, Multiple personalities, Bipolar disorder, Depressive psychosis, Schizophrenia, Major depression or Neurosis
- ☐ Other mental or behavioral health disorder not listed
- ☐ NONE OF THE ABOVE

M. METABOLIC, ENDOCRINE, IMMUNOLOGICAL

- ☐ Diabetes, Rheumatoid arthritis, Hyperthyroidism
- ☐ HIV/ AIDS
- ☐ Other metabolic, endocrine disorder, or immunological conditons not listed
- ☐ NONE OF THE ABOVE

N. MUSCULOSKELETAL

- ☐ Back or neck pain or injury currently under treatment or controlled with medication
- ☐ Back or neck pain or injury for which further treatment or surgery has been recommended
- ☐ Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment
- ☐ Herniated disc not surgically corrected
- ☐ Herniated disc surgically corrected, fully resolved and no longer under treatment
- ☐ Inguinal hernia for which further treatment or surgery has been recommended
- ☐ Lupus/SLE, Osteomyelitis, Joint replacement surgery
- ☐ Osteoarthritis
- ☐ Scoliosis/spinal curvature for which further treatment or surgery has been recommended
- ☐ Scoliosis surgically corrected within the past 12 months
- ☐ Umbilical hernia for which further treatment or surgery has been recommended
- ☐ Other musculoskeletal condition not listed
- ☐ NONE OF THE ABOVE

O. REPRODUCTIVE DISORDER, FEMALE

- ☐ Abnormal pap smear within past 12 months
- ☐ Infertility including In vitro fertilization
- ☐ Irregular monthly menstrual periods that are not 28-30 days between the first day of one period and the first day of the next period
- ☐ Ovarian cysts controlled by birth control
- ☐ Ovarian cysts fully recovered, no pending treatment or surgery
- ☐ Ovarian cysts pending treatment or surgery
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Uterine fibroids operated/treated and fully recovered
- ☐ Uterine fibroids unoperated
- ☐ Other female reproductive disorder not listed
- ☐ NONE OF THE ABOVE

P. REPRODUCTIVE DISORDER, MALE

- ☐ Benign prostatic hypertrophy with abnormal PSA levels
- ☐ Prostatitis
- ☐ Other male reproductive disorder not listed
- ☐ NONE OF THE ABOVE

Q. SEXUALLY TRANSMITTED DISEASE

- ☐ Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months
- ☐ Genital warts with outbreak in last 12 months
- ☐ Gonorrhea, Chlamydia, Trachomatous cervicitis
- ☐ Syphilis
- ☐ Other sexually transmitted disease not listed
- ☐ NONE OF THE ABOVE

2. **At any time in the last 2 years,** have you or any applicant been seen in a hospital emergency room or been admitted to a hospital, outpatient surgical center, or other treatment facility?
☐ Yes ☐ No

3. **Within the last 3 years**, have you or any applicant undergone any surgery, treatment, examination, evaluation, or test for any medical or mental health condition?
☐ Yes ☐ No

4. **Within the last 3 years**, have you or any applicant been advised to have, but have not yet had, any surgery, treatment, examination, evaluation, or test for any medical or mental health condition?
☐ Yes ☐ No

5. **In the last 5 years**, have you or any applicant taken or used any illegal drugs, or any prescription drugs without a prescription?
☐ Yes ☐ No

6. **In the last 5 years**, have you or any applicant been seen or examined by a physician, health care professional, counselor, therapist, social worker, or any medically related professional for symptoms of alcohol and/or substance abuse, or participated in or been advised to participate in any program?
☐ Yes ☐ No

7. **Within the past 2 years**, have you sought advice or treatment from a medical professional for a:
a) physical exam?
☐ Yes ☐ No
b) minor illness or injury now resolved without a recommendation of further treatment?
☐ Yes ☐ No

8. Do you or any applicant **currently** have any other condition, disorder, abnormality, or symptom not listed on this application, even if not currently under treatment?
☐ Yes ☐ No

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

Question Number	Person Treated	Physician Name and Telephone Number	Specific Diagnosis/ Name of Illness/Lab Test Results/ Purpose of Visit	Treatment Dates			Was Surgery/ Procedure/ Treatment Performed?		Description of Surgery/ Procedure/Treatment & Date(s)	Name & Dosage of Medication & Dates of Use	
				Start/ End	Full Recovery					Start	End
1-N	Sue	Dr. Smith 404-444-4444	Herniated disk	12/2009-12/2010	✔ Yes	No	✔ Yes	No	Diskectomy 12/2010	Ibuprophen 600 mg. 2x daily 12/1/10	12/31/10
					Yes	No	Yes	No			
					Yes	No	Yes	No			
					Yes	No	Yes	No			
					Yes	No	Yes	No			
					Yes	No	Yes	No			
					Yes	No	Yes	No			

10. **(a) In the past year**, have you or any applicant been prescribed, taken, or been advised to take any prescription medication for any reason (including Depo-Provera or other birth control medication) that has not been disclosed in question 9?

☐ Yes ☐ No

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

Person Treated	Name & Dosage of Medication & Dates of Use		Reason Why Medication Was Prescribed	Physician Name and telephone number
	Start	End		
Sue	Amoxicillin 100 mg. 2x daily		Sinus Infection	Dr. Smith 404-444-4444
	10/1/2011	10/11/2011		

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

11. **(a)** Are you or any individual applying for coverage currently pregnant, an expectant father, or in the process of adopting a child?

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

(b) Do you or any individual applying for coverage plan to be a surrogate parent (mother or father) or plan to engage someone to provide that service for you?

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

4. OTHER HEALTH-RELATED QUESTIONS

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

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

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

	Self	Spouse	D1	D2	D3
Beer					
Wine					
Hard liquor					

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

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

3. **(a)** Have you or any applicant **ever** used tobacco products?

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

(b) If Yes, for how long?

9 years or less	☐ Self	☐ Spouse
10-19 years	☐ Self	☐ Spouse
20+ years	☐ Self	☐ Spouse

(c) Have you quit?

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

If Yes, when?

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

(d) If you or your spouse smoke or smoked cigarettes, what is or was your average daily usage?

1/2 pack or less	☐ Self	☐ Spouse
1 pack	☐ Self	☐ Spouse
1½ packs	☐ Self	☐ Spouse
2 or more packs	☐ Self	☐ Spouse
N/A	☐ Self	☐ Spouse

5. APPLICATION AGREEMENT

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

THIS AGREEMENT IS SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

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

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

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

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

4. Our decision to accept you or your family member (except for any eligible Applicant under the age of 19 who must be accepted under applicable law) for coverage will be made after we have reviewed the medical history information pertaining to you and any other Applicant disclosed in Sections 3 and 4 of this application. We can only accept dependents under the age of 19 when a parent is approved and enrolled in a family plan.

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

I authorize the disclosure of premium billing and claim payment information to my broker of record and my spouse (if applicable) to expedite the servicing of my account.
☐ Yes ☐ No

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

Signature of Primary Applicant Date

Signature of Spouse Date

Signature of Dependent (age 18 or older) Date

Signature of Dependent (age 18 or older) Date

Signature of Dependent (age 18 or older) Date

A representative of Kaiser Permanente may contact you.

6. RELEASE OF INFORMATION

RELEASE AUTHORIZATION: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional who has provided any services to me or my family member applying for, or having membership in any Kaiser Foundation Health Plan product (each, an "Applicant"), or any insurance or reinsurance company, pharmacy benefits manager, or third party administrator to give Kaiser Foundation Health Plan of Georgia, Inc., or its affiliates ("Kaiser Permanente"), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, sexually transmitted diseases, HIV (Human Immunodeficiency Virus) status, or AIDS (Acquired Immune Deficiency Syndrome) ("Medical Information") of the Applicant. However, Medical Information does not include genetic information or "Psychotherapy Notes" (as defined by 45 C.F.R. ß 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer or insurance company for the purpose of review, investigation or evaluation of enrollment or of any claim for benefits after enrollment. I further authorize Kaiser Permanente to disclose to my Kaiser Permanente agent or broker any and all information related to the declination of this application should Kaiser Permanente decline any applicant hereon. I will sign new authorizations, if necessary, so that, in connection with the review, investigation or evaluation of enrollment or of any claim for benefits, Kaiser Permanente may request, use and disclose Medical Information and "Psychotherapy Notes." Medical Information, once disclosed, may no longer be protected by Federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation or evaluation of any claim for benefits for an Applicant if that Applicant is still a member of any Kaiser Foundation Health Plan. A photocopy of this authorization is as valid as the original, and I and my Kaiser Permanente agent or broker are entitled to receive a copy of this form. I may revoke this authorization (to the extent applicable to my Medical Information) at any time prior to its expiration. However, revocation is not effective to the extent that Kaiser Permanente has already taken action in reliance on it, or for so long as Kaiser Permanente may contest my enrollment or of any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's Notice of Privacy Practices.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

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

Signature of Primary Applicant	Date
Signature of Spouse	Date
Signature of Dependent (age 18 or older)	Date
Signature of Dependent (age 18 or older)	Date
Signature of Dependent (age 18 or older)	Date

7. BROKER INFORMATION

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

Applicant's Name

Holly G. Conley
Name of Broker *(Please Print)*

5 Dunwoody Park South, Suite 113
Address

Atlanta,
City

Georgia 30338
State Zip Code

770-396-9517 770-396-4318
Phone Fax

holly@insurance-now.com
Email

BROKER'S STATEMENT:

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

Holly G. Conley
Broker Signature

Date

Broker Number	General Agency Stamp (if applicable)
[ ] [H] [-] [7] [1]	

For Office Use Only:

Underwriter

Effective Date

8. PAYMENT OPTIONS

☐ Automatic Draft Plan*

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

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

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

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

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

Bank Name

Member (Depositor) Account Number:

Bank Address

Type of account (check one)

☐ Savings Account ☐ Checking Account ☐ Other

(Please attach a voided check)

Member Name(s) *(Please Print)*

Member Signature

Depositor Signature Date

2nd Depositor Signature (if Joint Account) Date

☐ Payment by Debit/Credit Card

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

Type of Card Credit Card Number: Expiration Date

Name As It Appears On Card Signature

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

☐ Payment by Monthly Invoice†

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

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

PERFORATION (DO NOT PRINT)