Application for health coverage

Individual and Family Plans

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, don't complete this application. You must apply for coverage through the Health Insurance Marketplace at healthcare.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, 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. If you didn't receive this guide, you can find it at **buykp.org/apply**, or call **1-800-494-5314** to request a copy. Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- To avoid paying for 2 plans, if you are enrolled in another plan through the Health Insurance Marketplace or through Kaiser Permanente, you should end that plan before the start date of your new plan. To avoid a gap in coverage, be sure that plan ends the day before your new plan starts.
- **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:

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

  Or send it by secure fax to: **1-866-816-5139**

  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 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.

Primary applicant

STEP 1: 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.

Date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

For more information on minimum essential coverage and qualifying triggering events, please refer to the Enrolling During a Special Enrollment Period guide. To request a copy, please call **1-800-494-5314.**

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

- ☐ Loss of health care 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
- ☐ Child support order or other court order to cover a child
- ☐ Permanent relocation
- ☐ Change in eligibility for federal financial assistance through the Health Insurance Marketplace†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by the Health Insurance Marketplace

*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 healthcare.gov.

STEP 2: 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
☐ KP GA Bronze 4500/20	☐ KP GA Silver 2000/30	☐ KP GA Gold 500/20
☐ KP GA Bronze 5700/50	☐ KP GA Silver 2750/20% HSA	☐ KP GA Gold Std 1250/20
☐ KP GA Bronze 6200/40% HSA	☐ KP GA Silver 3000/30	☐ KP GA Gold 1500/20
☐ KP GA Bronze Std 6650/45	☐ KP GA Silver Std 3500/30	

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 7150/0

For information about health 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 **1-800-634-4579,** 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 18, the child is the primary applicant.

First name

Social Security number

Last name

Phone

MI

Former health record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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

City

State

ZIP code

County

Mailing 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.*

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

Spouse/domestic partner to be covered

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

First name

MI

Last name

Social Security number

Former health record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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

Parent or legal guardian (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number

Preferred language spoken (if not English)

Preferred language read (if not English)

(continues)

Primary applicant

STEP 3: Enter your information *(continued)*

Dependents to be covered

If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

1 First name

MI

Last name

Social Security number

Former health record number (if any) -

Home state (if any)

Gender: ☐ Male ☐ Female

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

Relationship to primary applicant

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

Last name

Social Security number

Former health record number (if any) -

Home state (if any)

Gender: ☐ Male ☐ Female

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

Relationship to primary applicant

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

3 First name

MI

Last name

Social Security number

Former health record number (if any) -

Home state (if any)

Gender: ☐ Male ☐ Female

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

Relationship to primary applicant

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

4 First name

MI

Last name

Social Security number

Former health record number (if any) -

Home state (if any)

Gender: ☐ Male ☐ Female

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

Relationship to primary applicant

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

STEP 4: 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

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 5: 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 have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.

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)

X

Date (mm/dd/yyyy) / /

Dependent (18 and older)

Primary applicant

STEP 6: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Amount for your first month's premium

$, .

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 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. 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 **1-866-278-9502.**

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 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) / /

Primary applicant

STEP 7: 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 (the 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 ID number

Agency name

Phone - -

Fax - -

Email address