

Please print or type in black ink only.

FOR EMPLOYER / GROUP USE ONLY

EMPLOYER NAME

GROUP NO.	SUBGROUP NO.	BILLGROUP	DATE OF HIRE (MM/DD/YYYY)	EFFECTIVE DATE (MM/DD/YYYY)
□□□□□□	□□□□	□□	□□□□□□□□	□□□□□□□□

SECTION 1 – EMPLOYEE NAME

LAST NAME

FIRST NAME

MI

SUFFIX

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SOCIAL SECURITY NUMBER

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SECTION 2 – REASON FOR APPLICATION

PLEASE CHECK ONE:

- | | |
|---|---|
| <input type="checkbox"/> New Group or Annual Open Enrollment Period | <input type="checkbox"/> Loss of coverage |
| <input type="checkbox"/> New Hire | <input type="checkbox"/> Waiver of coverage |
| <input type="checkbox"/> Retiree | <input type="checkbox"/> Other _____ |

SECTION 3 – REASON FOR CHANGE

 PLEASE CHECK ONE OF THE FOLLOWING IF YOU ARE **ADDING** DEPENDENTS: *(Complete sections 5,6,7,8,11)*

 PLEASE CHECK ONE OF THE FOLLOWING IF YOU ARE **DELETING** DEPENDENTS: *(Complete sections 5,6,7,8,11)*

<input type="checkbox"/> Birth MM/DD/YYYY <input type="checkbox"/> Adoption* □□□□□□□□ <input type="checkbox"/> Marriage* □□□□□□□□ <input type="checkbox"/> Common law □□□□□□□□ <input type="checkbox"/> Loss of other coverage □□□□□□□□ <input type="checkbox"/> Other _____ □□□□□□□□	<input type="checkbox"/> Over age limit MM/DD/YYYY <input type="checkbox"/> Divorce □□□□□□□□ <input type="checkbox"/> Deceased* □□□□□□□□ <input type="checkbox"/> Other _____ □□□□□□□□
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SECTION 4 – OTHER CHANGES (PLEASE CHECK ALL THAT APPLY)

- | | |
|--|---|
| <input type="checkbox"/> Name Change <i>(Complete sections 6, 7, 10)</i> _____ | <input type="checkbox"/> Address <i>(Complete sections 6, 10)</i> |
| Previous Name _____ | <input type="checkbox"/> Telephone <i>(Complete sections 6, 10)</i> |

SECTION 5 – TYPE OF PLAN

- PLEASE CHECK ONE:
- | | | |
|---|---|--|
| <input type="checkbox"/> HMO Traditional Plan | <input type="checkbox"/> HMO Deductible Plan | <input type="checkbox"/> HMO High Deductible Health Plan |
| <input type="checkbox"/> Added Choice (POS) | <input type="checkbox"/> Added Choice (POS) Deductible Plan | <input type="checkbox"/> PPO |
| | | <input type="checkbox"/> Out-of-Area (PPO) |

*Additional documentation may be required.



SECTION 6 – EMPLOYEE INFORMATION

LAST NAME FIRST NAME MI SUFFIX
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 ADDRESS
 APARTMENT NUMBER CITY STATE ZIP CODE
 HOME PHONE WORK PHONE
 PRIMARY CARE PHYSICIAN (PCP) NAME IF SELECTING HMO OR ADDED CHOICE PCP ID

SECTION 7 – FAMILY / DEPENDENT INFORMATION *

ADD DELETE SPOUSE DOMESTIC PARTNER DEPENDENT CHILD OTHER _____
 LAST NAME FIRST NAME MI SUFFIX
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 PRIMARY CARE PHYSICIAN (PCP) NAME IF SELECTING HMO OR ADDED CHOICE PCP ID

ADD DELETE DEPENDENT CHILD OTHER _____
 LAST NAME FIRST NAME MI SUFFIX
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 PRIMARY CARE PHYSICIAN (PCP) NAME IF SELECTING HMO OR ADDED CHOICE PCP ID

ADD DELETE DEPENDENT CHILD OTHER _____
 LAST NAME FIRST NAME MI SUFFIX
 SOCIAL SECURITY NUMBER MEDICAL RECORD NUMBER (IF ANY) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE
 PRIMARY CARE PHYSICIAN (PCP) NAME IF SELECTING HMO OR ADDED CHOICE PCP ID

* To add additional dependents, ask your HR representative for an additional dependent form.



EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

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SECTION 9 – TERMS, CONDITIONS AND AUTHORIZATIONS

Ohio Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I understand and agree that any material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Ohio (Health Plan) and /or Kaiser Permanente Insurance Corp (KPIC), as applicable, of any material change in health status or impairment or disease that occurs between the date of application and the effective date of coverage will be deemed to be a material misrepresentation and may result in the rescission of my coverage as well as the coverage of my spouse, and covered dependents (if any), without liability to Health Plan and /or KPIC, as applicable, and /or the Ohio Permanente Medical Group, Inc.

I understand and agree that if the application is accepted by Health Plan and /or KPIC, as applicable, the benefits for which I, my spouse, and dependents (if any) will be determined in accordance with the agreement between my employer, Health Plan, and /or KPIC, as applicable. I further understand and agree that I, my spouse and dependents (if any) will be bound by the terms and conditions of such agreements. I authorize the deduction from my wages amounts necessary to pay the employee portion of the premiums for my, my spouse's, and covered dependents' (if any) Health Plan and /or KPIC, as applicable, coverage. I understand that to be eligible for coverage and remain eligible, I must satisfy the eligibility requirements in my employer's agreement with Health Plan and /or those set forth under the *KPIC Group Policy /Certificate of Insurance* as applicable, and that the information provided in this application may be relied on and used to determine my, my spouse's, and my dependents' (if any) eligibility for coverage.

I agree to provide any documentation, including tax returns, payroll records, etc., necessary to establish that I, my spouse, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage.

I, my spouse, and my dependents (if any) listed in Section 7 of this application understand that we are entitled to receive a copy of this application.

I hereby apply for coverage from Health Plan and /or KPIC for myself, my spouse, and for any eligible dependents listed and authorize my employer to make deductions, if any, required as my contribution. The information provided above is true and correct to the best of my knowledge and meets the eligibility guidelines listed in the application instructions. I understand that my coverage and benefits may be affected by my failure to provide complete and accurate information.

I hereby assign Kaiser Permanente authorization to bill any other group health policy that may cover me, my spouse, or my dependents for all covered services provided or arranged by Plan physicians as long as I am a member of this Plan. I understand that this arrangement does not limit my rights to receive reimbursement for services I receive from non-Plan providers. I also hereby authorize the release of medical records to Kaiser Permanente for services payable under this contract.

Health Plan and KPIC each have a network of participating physicians and other providers. My choice of physician or provider may determine the level of benefits I receive. Participating physicians and providers are subject to change. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a *Provider Directory*, or obtain a list of current participating physicians and other providers by calling Customer Relations at **1-800-686-7100**.

Any person obligated for any part of a premium may cancel such an agreement within 72 hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to KFHO or its agents or other representatives. Notice of cancellation is considered given when the prospective subscriber mails the notice to Health Plan.

SECTION 10 – SIGNATURE

IMPORTANT: Your application cannot be processed without your signature. Please read this form before signing.

I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described above. (IMPORTANT: All applications MUST be signed.)

Applicant Signature

Date

____/____/____



EMPLOYEE LAST NAME

□□□□□□□□□□□□□□□□

SOCIAL SECURITY NUMBER

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SECTION 11 – ELIGIBILITY:

Individuals will be accepted for enrollment only if they: (1) Meet all eligibility requirements established by the group and agreed upon by KFHP and KPIC; (2) Meet all applicable requirements set forth in the **Group Agreement** and/or the *KPIC Group Policy/Certificate of Insurance*, as applicable; and (3) Reside permanently in the service area (Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Stark, Summit, and Wayne counties), or you reside in a contiguous county and work in the service area, and the group has chosen an expanded enrollment provision.

GUIDELINES FOR ELIGIBILITY:

- 1. Subscriber must be either
 - a) an employee of group; or
 - b) entitled to coverage based on KFHP approved group contract; or
 - c) eligible for continuation of coverage (i.e. COBRA).
- 2. Family Dependent must be either
 - a) the subscriber’s spouse; or
 - b) unmarried dependent child of the subscriber or subscriber’s spouse under the group’s specified age limit that meets dependency requirements; or
 - c) any other unmarried dependent person under the group’s specified age limit entirely supported by the subscriber or the subscriber’s spouse permanently residing in the subscriber’s household* and for whom the subscriber or subscriber’s spouse is the legal guardian or court-appointed custodian. Copy of proof of guardianship or custodianship needs to be provided; or unmarried dependent child under a Qualified Medical Child Support Order (QMCSO).
- 3. Medicare-eligible applicants please contact your employer for additional information about the plan options available to you.

These requirements of eligibility are meant to be used only as guidelines. Please refer to your group’s specific **“Group Agreement”** and/or *KPIC Group Policy/Certificate of Insurance*, as applicable, for more detailed eligibility requirements. HMO and the Kaiser Permanente Tier 1 HMO benefit level of the Added Choice POS plans are provided by KFHP. The non-Participating Provider benefit levels of the Added Choice POS plans and PPO plans are underwritten by KPIC. KPIC is a subsidiary of KFHP, Inc.

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him/her. A more complete notice of our information privacy practices is available upon request.

*Except for dependent children as otherwise required by law

SECTION 12 – WAIVER OF COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer.

I refuse the following:

- All coverage
- Coverage for my spouse
- Coverage for my dependents

Reason for refusal: (Please check all appropriate boxes)

- Other group coverage sponsored by my employer
- Other group coverage sponsored by my spouse’s employer
- Other reasons (please explain)_____

Please provide name of carrier: _____

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I / they will be required to submit a Group Employee Enrollment and Change Form, and enrollment can occur only at open enrollment unless the late enrollee provisions apply.

Applicant Signature if Waiving Coverage

Date

_____/_____/_____



