Enrolling is Simple.
Just Follow These 2 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 661-333-1181 fax: 661-587-0659

Step 2

SEND THE COMPLETED APPLICATION TO:

Ginn Insurance Services
9805 Vanessa Ave.
Bakersfield, CA 93312

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 661-333-1181

Thank you for choosing...

KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: Please answer all questions and print or type **using ink only**. You should sign this application only if you understand each question and agree to the response provided—even if a broker assists you with the application. **If you have questions about completing this application (in English or another language), please call 1-800-232-5100. We will provide translation services and other language assistance free of charge if you need it. Or, if you are working with a broker, please call him or her for assistance.**

Kaiser Foundation Health Plan, Inc. (KFHP), offers family coverage and rates if everyone selects the same benefit plan. If you want coverage for your family on the same KFHP plan, please complete one application for the family. If one family member wants a different benefit plan, he or she must complete a separate application. If a family member wishes to confidentially complete an application, even if selecting the same benefit plan, he or she may either request additional forms from us or use a photocopy of this application.

Health insurance coverage provided by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc., is offered to individuals only. It does not include coverage for dependents. If you want coverage for yourself, you have the choice of KFHP or KPIC. If additional family members want to apply for coverage provided by KPIC, each will need to fill out a separate application.

EXPEDITE YOUR APPLICATION – APPLY ONLINE NOW AT BUYKP.ORG/APPLYONLINE/CA.

I Application for Coverage (financially responsible party)

Last name

First name MI

Residential address for covered party:

Street address Apt./Unit #

City State ZIP

( ) ❑ Day ❑ Evening
Home phone

( ) ❑ Day ❑ Evening
Work phone

E-mail address

How do you prefer to be contacted? ❑ E-mail ❑ U.S. mail

Primary spoken language:
❑ English
❑ Other (please specify) ____________

II Account Information

Please check all boxes that apply.

1. **Are you adding a family member to an existing Individuals and Families Plan account?**
   ❑ Yes ❑ No

2. **Are you switching coverage/plan selection from an existing Individuals and Families Plan account?**
   ❑ Yes ❑ No

3. **Are you applying for a new Individuals and Families Plan account?**
   ❑ Yes ❑ No

(continues on page 2)

II Account Information *(continued)*

4. Which plan would you like to apply for? (Select only one plan.)

Plans offered by KFHP:[1]
- ❑ Copayment 25
- ❑ Copayment 50
- ❑ Deductible 20/500
- ❑ Deductible 25/1000
- ❑ Deductible 30/1500
- ❑ Deductible 0/1500 with HSA
- ❑ Deductible 0/2700 with HSA
- ❑ Deductible 30/2700 with HSA

Plans offered by KPIC:[1]
- ❑ Deductible 40/3000 NM
- ❑ Deductible 40/4000 NM with HSA
- ❑ Deductible 0/5000 WM with HSA
- ❑ Deductible 50/5000 NM

5. Are you applying for the optional dental plan?

❑ Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.

❑ No

6. Because all applicants applying for an Individuals and Families plan are subject to medical review, there is the possibility that one or more members of a family (or a single applicant) may not qualify for the plan for which they apply.

If you or another family member **does not** qualify, may we complete the enrollment for family members who have been approved?

❑ Yes ❑ No

7. If you or another family member does not qualify for the Individuals and Families plan you selected but does qualify for another Individuals and Families plan, we need your instruction:

I am willing to accept enrollment in a plan different from the one I originally selected. I will be notified of the plan I qualify for and given the option of canceling.

❑ Yes ❑ No

If you do not qualify for any Individuals and Families plan, you may qualify for a HIPAA plan without medical review. Please review and complete Section IX, "HIPAA Eligibility Questionnaire and Request for Enrollment," on page 21.

Note: All applications must be accompanied by payment information. Please make certain that you have provided the necessary information on page 15 of this application.

[1] For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* or *Certificate of Insurance* for a particular plan, please call us at 1-800-232-5100 or contact your broker.

III Family Members to Be Covered

(Please fill out only the "Self" parts of this section if you are applying for KPIC coverage. Complete this entire section only if you are applying for KFHP family coverage.) **If any family members have a different home address than the applicant, please list that address under their names. Attach additional pages if necessary.**

Self:

Last name | First name | Previous name (if any) | Date of birth | M/F

Height (ft/in) | Weight (lbs) | Marital status | Current or previous Kaiser Permanente medical record number (if any)

Social Security number | Primary spoken language: ❑ English ❑ Other (please specify) ______

Spouse/Domestic partner:

Last name | First name | Previous name (if any) | Date of birth | M/F

Height (ft/in) | Weight (lbs) | Marital status | Current or previous Kaiser Permanente medical record number (if any)

Social Security number | Home address (if different than applicant's)

Primary spoken language: ❑ English ❑ Other (please specify) ______

Child:

Last name | First name | Previous name (if any) | Date of birth | M/F

Height (ft/in) | Weight (lbs) | Marital status | Current or previous Kaiser Permanente medical record number (if any)

Social Security number | Home address (if different than applicant's) | Full-time student ❑ Yes ❑ No

Primary spoken language: ❑ English ❑ Other (please specify) ______

Child:

Last name | First name | Previous name (if any) | Date of birth | M/F

Height (ft/in) | Weight (lbs) | Marital status | Current or previous Kaiser Permanente medical record number (if any)

Social Security number | Home address (if different than applicant's) | Full-time student ❑ Yes ❑ No

Primary spoken language: ❑ English ❑ Other (please specify) ______

Child:

Last name | First name | Previous name (if any) | Date of birth | M/F

Height (ft/in) | Weight (lbs) | Marital status | Current or previous Kaiser Permanente medical record number (if any)

Social Security number | Home address (if different than applicant's) | Full-time student ❑ Yes ❑ No

Primary spoken language: ❑ English ❑ Other (please specify) ______

(continues on page 4)

III Family Members to Be Covered *(continued)*

For each individual listed on page 3, please give the name of the family member's current or most recent primary care physician, along with his or her address and telephone number. Attach additional pages if necessary.

(Please fill out only the "Self" section if you are applying for KPIC coverage. Complete this entire section only if you are applying for family coverage on a KFHP plan.)

Self:
Doctor ______
Phone ______
Date last visited ______
Address ______
City, State, ZIP ______

Child: ______
Doctor ______
Phone ______
Date last visited ______
Address ______
City, State, ZIP ______

Child: ______
Doctor ______
Phone ______
Date last visited ______
Address ______
City, State, ZIP ______

Spouse/Domestic partner:
Doctor ______
Phone ______
Date last visited ______
Address ______
City, State, ZIP ______

Child: ______
Doctor ______
Phone ______
Date last visited ______
Address ______
City, State, ZIP ______

For each individual for whom you are applying, please give the name of his or her current or most recent health care coverage provider. Attach additional pages if necessary.

Self ______ ❑ Current **or** Date ended ___ / ___ / ___ **or** ❑ Not insured

Spouse/Domestic partner ______ ❑ Current **or** Date ended ___ / ___ / ___ **or** ❑ Not insured

Child ______ ❑ Current **or** Date ended ___ / ___ / ___ **or** ❑ Not insured

Child ______ ❑ Current **or** Date ended ___ / ___ / ___ **or** ❑ Not insured

Child ______ ❑ Current **or** Date ended ___ / ___ / ___ **or** ❑ Not insured

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a member of KFHP or insured by KPIC. **Each applicant for a KFHP plan or a KPIC insurance policy must pass medical review regardless of current or previous Kaiser Permanente coverage through KFHP or KPIC.** Omissions or incomplete answers regarding your and, if applicable, your family member's (or members') health history will delay processing of your application. **Either intentional or willful misrepresentation of an applicant's health history can result in rescission of coverage for that applicant (see Section VIII for details).**

This application becomes part of your Kaiser Permanente record. If you need assistance completing this medical questionnaire, you may call our Member Service Call Center toll free at **1-800-464-4000**, or you may call your broker. Kaiser Permanente does not discriminate in its decision-making based on: race; color; national origin; ancestry; religion; sex (including gender, gender identity, or gender-related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth); marital status; sexual orientation; age; or genetic information.

Note: This is a family-level questionnaire. You must answer each question for yourself and for everyone you are applying for. Please answer Yes or No to each question. Each question that you answer Yes and each condition that you check Yes requires an explanation. Please see the chart on page 13 and provide the information requested.

Check the Yes or No box for each letter subquestion. Every line must be answered Yes or No. When you answer each question, answer not only for yourself but for everyone you are applying for.

1. ***Within the last 12 months***, were you (or anyone you are applying for) hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?

   ❑ Yes ❑ No

2. ***Within the last 12 months***, have you (or anyone you are applying for) sought advice or treatment from a medical professional's office?

   ❑ Yes ❑ No a) Physical exam
   ❑ Yes ❑ No b) Minor illness or injury now resolved and without a recommendation of further treatment; for example, cold, allergic reaction, flu, sore throat, cut requiring stitches
   ❑ Yes ❑ No c) Regular chiropractic visits
   ❑ Yes ❑ No d) Prenatal care
   ❑ Yes ❑ No e) Psychological counseling
   ❑ Yes ❑ No f) Medication management
   ❑ Yes ❑ No g) A reason not listed above

3. ***Within the last 3 years***, have you (or anyone you are applying for) been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?

   ❑ Yes ❑ No

4. ***Within the last 3 years***, have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with ***your (or his/her)*** alcohol or substance abuse?

   ❑ Yes ❑ No

(Medical questionnaire continues on page 6.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

5. ***Within the last 3 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any skin/dermatological disorders?

❑ Yes ❑ No a) Acne
❑ Yes ❑ No b) Psoriasis
❑ Yes ❑ No c) Burns
❑ Yes ❑ No d) Keloids requiring plastic surgery
❑ Yes ❑ No e) Cosmetic or reconstructive surgeries, revisions
❑ Yes ❑ No f) A skin or dermatological condition not listed above

6. ***Within the last 3 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any disorders of the eyes, ears, nose, or throat?

❑ Yes ❑ No a) Glaucoma
❑ Yes ❑ No b) Cataracts, cataract surgery for one or both eyes
❑ Yes ❑ No c) Crossed eyes
❑ Yes ❑ No d) Detached retina
❑ Yes ❑ No e) Macular degeneration
❑ Yes ❑ No f) Deviated septum
❑ Yes ❑ No g) Sleep apnea, chronic snoring, or unresolved insomnia
❑ Yes ❑ No h) Nasal and/or throat polyps
❑ Yes ❑ No i) A condition of the eyes, ears, nose, or throat not listed above

7. Have you (or anyone you are applying for) ever used tobacco, including snuff and chewing or other smokeless tobacco?

❑ Yes ❑ No

If No, skip to Question 8. If Yes, answer the following questions:

Please provide his or her name: ________________________________

❑ Yes ❑ No a) Currently use or have used in the past for ____ years
❑ Yes ❑ No b) If you (or anyone you are applying for) smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:

Cigarettes: ____ packs per day
Pipes: _____ bowls per day
Cigars: _____ per day

(If this question pertains to more than one person applying, please list additional name[s] and answers on page 13, using the format above.)

8. ***Within the last 5 years***, have you (or anyone you are applying for) taken or used illegal drugs or prescription drugs not prescribed by a medical professional for yourself (or anyone you are applying for)?

❑ Yes ❑ No

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

9. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any brain, neurological, or nervous disorder?

❑ Yes ❑ No a) Multiple sclerosis
❑ Yes ❑ No b) Autism
❑ Yes ❑ No c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
❑ Yes ❑ No d) Seizures treated with more than 2 medications for control
❑ Yes ❑ No e) Seizures under control with 2 or fewer medications
❑ Yes ❑ No f) Most recent seizure within the last 12 months
❑ Yes ❑ No g) Alzheimer's disease
❑ Yes ❑ No h) A brain, neurological, or nervous disorder not listed above

10. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any heart or cardiovascular disorders?

❑ Yes ❑ No a) Aneurysm
❑ Yes ❑ No b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment
❑ Yes ❑ No c) Chest pain
❑ Yes ❑ No d) Heart attack or angina
❑ Yes ❑ No e) Congestive heart failure
❑ Yes ❑ No f) Angioplasty or coronary artery bypass
❑ Yes ❑ No g) Pacemaker
❑ Yes ❑ No h) Tachycardia or other heart arrhythmia
❑ Yes ❑ No i) Other heart disease or valve disease
❑ Yes ❑ No j) Current medication(s) to control heart disease or cardiovascular symptoms
❑ Yes ❑ No k) A heart or cardiovascular condition not listed above

11. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any respiratory disorders?

❑ Yes ❑ No a) Chronic asthma treated with medications for control
❑ Yes ❑ No b) Asthma treated with prednisone therapy
❑ Yes ❑ No c) Asthma treated only with occasional use of inhalers
❑ Yes ❑ No d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months
❑ Yes ❑ No e) Emphysema
❑ Yes ❑ No f) Chronic bronchitis
❑ Yes ❑ No g) Chronic obstructive pulmonary disease
❑ Yes ❑ No h) Cystic fibrosis
❑ Yes ❑ No i) Pulmonary tuberculosis, active or arrested
❑ Yes ❑ No j) A lung or respiratory disorder not listed above

(Medical questionnaire continues on page 8.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

12. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any muscle or bone disorders?

❑ Yes ❑ No a) Back or neck pain or injury currently under treatment or controlled with medication
❑ Yes ❑ No b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment
❑ Yes ❑ No c) Back or neck pain or injury for which further treatment or surgery has been recommended
❑ Yes ❑ No d) Inguinal hernia that has been repaired
❑ Yes ❑ No e) Inguinal hernia not repaired
❑ Yes ❑ No f) Umbilical hernia that has been repaired
❑ Yes ❑ No g) Umbilical hernia not repaired
❑ Yes ❑ No h) Lupus/SLE
❑ Yes ❑ No i) Chronic disabling arthritis
❑ Yes ❑ No j) Arthritis requiring daily prescription medication
❑ Yes ❑ No k) Osteomyelitis
❑ Yes ❑ No l) Joint replacement surgery
❑ Yes ❑ No m) Orthopedic or arthritic conditions that interfere with daily living
❑ Yes ❑ No n) A musculoskeletal condition not listed above

13. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any metabolic or endocrine (hormone) disorders?

❑ Yes ❑ No a) AIDS

California law prohibits an HIV test from being required or used by health care service plans or health insurance companies as a condition of obtaining coverage.

❑ Yes ❑ No b) Diabetes controlled with oral medication
❑ Yes ❑ No c) Diabetes controlled with insulin
❑ Yes ❑ No d) Diabetes controlled exclusively with diet and exercise
❑ Yes ❑ No e) Gestational diabetes
❑ Yes ❑ No f) High cholesterol
❑ Yes ❑ No g) Rheumatoid arthritis
❑ Yes ❑ No h) Muscular dystrophy
❑ Yes ❑ No i) Other immunological condition
❑ Yes ❑ No j) A metabolic or endocrine disorder not listed above

14. ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any congenital defects or developmental disorders?

❑ Yes ❑ No a) Down's syndrome
❑ Yes ❑ No b) Cerebral palsy
❑ Yes ❑ No c) Cleft palate or lip
❑ Yes ❑ No d) Club foot
❑ Yes ❑ No e) Congenital heart defect (specify type)
❑ Yes ❑ No f) Developmental delay
❑ Yes ❑ No g) Prematurity (for children up to 2 years old)
❑ Yes ❑ No h) A neurological or physical abnormality not listed above (specify)

Case ID: 216129

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

15. For men only: ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him) that any of you have, any of the following:

❑ Yes ❑ No a) Prostate condition requiring treatment, medication, or surgery
❑ Yes ❑ No b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months
❑ Yes ❑ No c) Genital warts
❑ Yes ❑ No d) Syphilis
❑ Yes ❑ No e) Gonorrhea
❑ Yes ❑ No f) Other sexually transmitted disease
❑ Yes ❑ No g) Impotence or erectile dysfunction
❑ Yes ❑ No h) Infertility
❑ Yes ❑ No i) Gender identity (role) disorder
❑ Yes ❑ No j) A male reproductive or genital disorder not listed above

16. For women only: ***Within the last 5 years***, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or her) that any of you have, any of the following:

❑ Yes ❑ No a) Ovarian cyst operated on within the last 12 months
❑ Yes ❑ No b) Ovarian cyst controlled by birth control pills
❑ Yes ❑ No c) Polycystic ovary syndrome (PCOS)
❑ Yes ❑ No d) Endometriosis
❑ Yes ❑ No e) Chronic pelvic pain or pelvic inflammatory disease
❑ Yes ❑ No f) Painful or irregular menstrual cycles
❑ Yes ❑ No g) Uterine fibroids
❑ Yes ❑ No h) Silicone breast implants
❑ Yes ❑ No i) Saline breast implants
❑ Yes ❑ No j) Infertility
❑ Yes ❑ No k) Miscarriage within the last 12 months
❑ Yes ❑ No l) Abnormal Pap test
❑ Yes ❑ No m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months
❑ Yes ❑ No n) Genital warts
❑ Yes ❑ No o) Syphilis
❑ Yes ❑ No p) Gonorrhea
❑ Yes ❑ No q) Other sexually transmitted disease
❑ Yes ❑ No r) In vitro fertilization
❑ Yes ❑ No s) Heavy periods (menstruation) causing low blood iron
❑ Yes ❑ No t) Gender identity (role) disorder
❑ Yes ❑ No u) A female reproductive or genital disorder not listed above

(Medical questionnaire continues on page 10.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

17. *Within the last 5 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any digestive system disorders?

❑ Yes ❑ No a) Ulcerative colitis or Crohn's disease
❑ Yes ❑ No b) Gastrointestinal bleeding
❑ Yes ❑ No c) Gastrointestinal polyps
❑ Yes ❑ No d) Unrepaired cystocele or rectocele
❑ Yes ❑ No e) Gallstones and gallbladder has not been removed
❑ Yes ❑ No f) Hepatitis A, B, C, or other, currently under treatment
❑ Yes ❑ No g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)
❑ Yes ❑ No h) Cirrhosis
❑ Yes ❑ No i) Hepatitis A, fully recovered with no symptoms and normal liver function tests
❑ Yes ❑ No j) Other liver condition
❑ Yes ❑ No k) A digestive system disorder not listed above

18. *Within the last 5 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any urinary tract disorders?

❑ Yes ❑ No a) Chronic kidney failure
❑ Yes ❑ No b) Nephrotic syndrome
❑ Yes ❑ No c) Polycystic kidneys
❑ Yes ❑ No d) Kidney failure
❑ Yes ❑ No e) Chronic kidney infections (more than 2 per year)
❑ Yes ❑ No f) Kidney infection, resolved with no further treatment required
❑ Yes ❑ No g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests
❑ Yes ❑ No h) Kidney removed with a recommendation for further treatment
❑ Yes ❑ No i) Kidney stones, currently
❑ Yes ❑ No j) Kidney stones within the last 24 months
❑ Yes ❑ No k) Interstitial cystitis
❑ Yes ❑ No l) A kidney or urinary tract disorder not listed above

19. *Within the last 5 years*, has a medical professional advised you (or anyone you are applying for) that any of you have any abnormal lab results?

❑ Yes ❑ No

(If Yes, please list with patient's [or patients'] name[s], name[s] of test[s], result[s], and date[s] on page 13.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

20. *Within the last 10 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any blood or circulatory system disorders?

❑ Yes ❑ No a) Stroke
❑ Yes ❑ No b) Transient ischemic attacks (TIA)
❑ Yes ❑ No c) Hemophilia
❑ Yes ❑ No d) Thalassemia major
❑ Yes ❑ No e) Von Willebrand's disease
❑ Yes ❑ No f) Other blood disorder
❑ Yes ❑ No g) Blood pressure over 150/90
❑ Yes ❑ No h) Currently taking 3 or more medications for hypertension
❑ Yes ❑ No i) Hypertension under control with medication
❑ Yes ❑ No j) A blood or circulatory system disorder not listed above

21. *Within the last 10 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any cancer?

❑ Yes ❑ No a) Any cancer with lymph node involvement or metastasis (spread to other tissue)
❑ Yes ❑ No b) Cancer of the brain, breast, blood, pancreas, prostate, urinary bladder, or esophagus; or myeloma, Kaposi's sarcoma, or non-Hodgkin's lymphoma
❑ Yes ❑ No c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended
❑ Yes ❑ No d) Cancer of the colon, kidney, liver, lung, ovary, or stomach
❑ Yes ❑ No e) Skin cancer that has not been removed and requires further treatment
❑ Yes ❑ No f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended
❑ Yes ❑ No g) Melanoma
❑ Yes ❑ No h) A cancer not listed above

22. *Within the last 10 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?

❑ Yes ❑ No

23. *Within the last 10 years*, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any psychological or mental health disorders?

❑ Yes ❑ No a) Mild depression/anxiety
❑ Yes ❑ No b) Major depression or neurosis
❑ Yes ❑ No c) Situational stress, anxiety, or depression no longer requiring treatment or medication
❑ Yes ❑ No d) Eating disorder (anorexia nervosa or bulimia)
❑ Yes ❑ No e) Suicide attempt
❑ Yes ❑ No f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia
❑ Yes ❑ No g) Hospitalization for a mental health condition
❑ Yes ❑ No h) A psychological or mental health condition not listed above

(Medical questionnaire continues on page 12.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

24. Are you (or anyone you are applying for) taking any prescription medications?
    ❑ Yes ❑ No

    (If Yes, please list the person's name, the medication[s], the dosage, frequency, name/address/phone number of the prescribing medical professional, and the reason the person is taking this medication on page 13.)

25. Do you (or anyone you are applying for) drink alcoholic beverages?
    ❑ Yes ❑ No

    If Yes, please indicate how much you (or anyone you are applying for) drink ***per week*** and provide his or her name: ____________________

    ❑ Yes ❑ No a) Beer: _____ bottles/cans
    ❑ Yes ❑ No b) Wine: _____ glass
    ❑ Yes ❑ No c) Hard liquor: _____ glass

    On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.

    (If more than one person drinks, please list separately on page 13 the person's name and the amount consumed, using the format above.)

26. Are you (or anyone you are applying for) ***currently*** pregnant or an expectant father? Or, do you (or anyone you are applying for) ***expect to be providing*** medical insurance coverage for a newborn or new adoptee within the next 9 months?
    ❑ Yes ❑ No

27. Do you (or anyone you are applying for) plan to be a surrogate parent (mother or father) ***within the next year*** or to engage someone to provide that service ***within the next year***?
    ❑ Yes ❑ No

28. For females age 11 and older:
    Please answer the questions below and provide your name: ____________________
    ❑ Yes ❑ No a) Have you ever menstruated?
    ❑ Yes ❑ No b) Are your menstrual periods regular? (If you answered No, please explain on page 13.)
    ❑ Yes ❑ No c) Are you still having regular menstrual periods? (If you answered Yes, please indicate the date you started your last normal menstrual period on page 13.)

    (If this question pertains to more than one family member, please list additional name[s] and answers on page 13, using the format above.)

29. Have you (or anyone you are applying for) been treated for, or advised by a medical professional that you have, a medical or health-related condition which you haven't indicated on this medical questionnaire? If so, please provide the appropriate details on the chart on page 13.
    ❑ Yes ❑ No

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

Please fill in the chart below for each question answered Yes or each condition answered Yes in the preceding questionnaire. Attach additional pages if necessary.

Question #	Letter	Family member affected	Explanation (diagnosis, treatment, current state)	Name of doctor giving diagnosis	Date of diagnosis

V Agent, Broker, and Representative Information

FOR APPLICANTS USING AN INSURANCE AGENT/BROKER/REPRESENTATIVE

Agent/Broker/Representative name Aaron Ginn

❑ Yes ❑ No Did you receive any assistance from an agent, a broker, or a representative of KFHP or KPIC in submitting this application? *Representative* means any representative of KFHP or KPIC who has provided you with such assistance.

I understand that the broker of record may receive monetary and/or non-monetary payments from Kaiser Foundation Health Plan, Inc., and/or Kaiser Permanente Insurance Company in connection with the purchase of this coverage.

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

X

Applicant signature (Use ink only.) **Today's date**

TO BE COMPLETED BY YOUR KAISER PERMANENTE–APPOINTED AGENT/BROKER/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

Notice to agent, broker, representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

X

Agent/Broker/Representative signature (Use ink only.) **Today's date**

Aaron Ginn
Name of agent/broker/representative (please print)

22358
Broker ID #

9805 Vanessa Ave.
Address

Bakersfield, CA 93312
City State ZIP

661-333-1181
Phone

661-587-0659
Fax

info@ginninsurance.com
E-mail address

VI Billing Information

Application must be accompanied by payment information for your initial premium. Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Last name

First name MI

Street address Apt./Unit #

City State ZIP

2. Effective date:

If approved, I would like to be enrolled with an effective date of:

- ❑ 1st of the month immediately following the date the application is approved (application must be received by the 23rd of the preceding month)
- ❑ 15th of the month following the date the application is approved (application must be received by the 8th of the month of intended enrollment)
- ❑ 1st of the month plus one additional month following the date the application is approved (application must be received by the 23rd of the preceding month)
- ❑ 15th of the month plus one additional month following the date the application is approved (application must be received by the 8th of the preceding month)

3. Credit/Debit card information: ❑ Credit ❑ Debit

❑ Visa ❑ Discover
❑ MasterCard ❑ American Express

Name as it appears on card

Credit/Debit card number

Credit/Debit card security number (Usually this is a three- or four-digit code on the back of the card near the signature line. In some cases, it may be on the front of the card.)

Expiration date

Note: Premiums for enrollments beginning on the 15th of the month will be prorated for that month only, after which the standard billing cycle (1st of the month) will apply.

(This page is intentionally left blank.)

VII Authorization to Release Medical Information

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 an *Applicant* (defined as me or any of my dependents applying for or having membership in any KFHP or KPIC product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, any Applicant's *Medical Information* (defined as **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, or AIDS [acquired immune deficiency syndrome]). However, Medical Information does not include genetic information or psychotherapy notes (as defined by 45 C.F.R. § 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 authorize Kaiser Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

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, AIDS-related information, and psychotherapy notes. Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed. I understand that, under California law, the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This authorization is effective on the date that the Applicant signs the application 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 KFHP Plan or insured by KPIC. 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.

(continues on page 18)

VII Authorization to Release Medical Information *(continued)*

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 any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's *Notice of Privacy Practices*.

X

Applicant/Financially responsible party (signing on behalf of self and all applicants/dependents under the age of 12) — **Today's date**

X

Applicant's spouse/Domestic partner — **Today's date**

X

Applicant/Dependent (age 12 or over) — **Today's date**

X

Applicant/Dependent (age 12 or over) — **Today's date**

X

Applicant/Dependent (age 12 or over) — **Today's date**

X

Applicant/Dependent (age 12 or over) — **Today's date**

Important: required signatures

- All Applicants age 18 and over must sign and date above on the appropriate signature line (head of household, spouse/domestic partner, dependent).
- All Applicants ages 12–17 must sign and date above on the appropriate signature line. (Minors have the right to control the release of certain types of medical history and records. We require that such minors sign in addition to their parents or legal guardians.)

Signature by parent or legal guardian represents authorization for himself/herself as well as authorization for minor children.

Use ink only.

VIII Conditions of Acceptance/Arbitration Agreement

You must fully answer each question in this application even though you may already be a KFHP member or a KPIC insured. If we decide to accept you for KFHP membership or issue you a KPIC policy, our decision will be based primarily on health information you provide in your application and during the enrollment process. If you are unsure of your current medical status, we strongly recommend that you ask your current or previous physician to clarify your specific condition. If you have or previously had coverage with KFHP or with KPIC, we will review your prior health history with Kaiser Permanente before making our decision. We may review your use of health care services for up to a year following your KFHP or KPIC enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KFHP or KPIC enrollment.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or any other family member applying for coverage under this application, take the time to make sure the information is accurate before submitting it to us. By signing this application, you represent that all responses are true, complete, and accurate to the best of your knowledge, and that if KFHP or KPIC accepts your application for coverage and/or the application of any of your dependents, the application will become part of the plan contract between you and any other applicant(s) and KFHP or KPIC.

Our decision to accept you (or any other applicant on this application) for coverage will be made only after we have thoroughly reviewed the medical history information pertaining to you and any other applicants disclosed in Section IV of this application. Our review will include our reasonable efforts to verify the accuracy and completeness of the information disclosed in Section IV. We are under a duty to complete this process of review and verification of applicant health history information (medical review).

If we determine that you or someone on your behalf either intentionally or willfully gave us incomplete or incorrect material information about the current or past health of any person applying for coverage on this application (or if such intentional or willful misrepresentation of health history was made at any time during the enrollment process), and our decision to accept the enrollment was based on this misinformation, we may rescind the membership of the person whose health history was so misrepresented. This means that we would completely void KFHP membership or the KPIC insurance policy of the misrepresenting individual as if no coverage had ever existed. If we approve the application for coverage for you or any other applicant on this application without properly completing medical review, we may only rescind coverage if we can support a claim that health history information disclosed in Section IV, or material health information not disclosed, was willfully misrepresented or omitted.

Before making any decision to rescind, we would notify you in writing why we believe we have grounds to rescind your membership. Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm that your actual health status at the time you were accepted for enrollment qualified you for individual plan enrollment. If, after considering your response, we decide to rescind, we will explain the basis for our decision and how you can appeal it.

Please note: If the intentionally or willfully provided incomplete or incorrect material health history information relates only to another person on the application (for example, a family member) and not to you as the subscriber, our rescission would not affect you or any other family member on the application because your (or his/her) health history did not lead to our decision to rescind. Conversely, if the intentionally or willfully provided incomplete or incorrect material health history information relates to you only, any other person applying for coverage on this application would not be affected because his/her health history on the application did not lead to our decision to rescind. If the coverage is lawfully rescinded, the rescinded individual may have to reimburse us for the reasonable value of any services that we provided or that we paid for on your (his/her) behalf, as legally permitted. Please refer to the *Membership Agreement* or *Certificate of Insurance* for more information about rescission of membership in KFHP or KPIC. Within 30 days, we will refund all applicable premiums except that we may subtract any amounts you owe us.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf.

Important note to the Applicant: You or your authorized representative may request a copy of your completed application. For more information, please call **1-800-634-4579**.

(continues on page 20)

VIII Conditions of Acceptance/Arbitration Agreement *(continued)*

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement* and in the *Certificate of Insurance*.

I am applying for coverage provided by KFHP or KPIC.

X ______________________________

Applicant/Financially responsible party **Today's date**

(Complete the following signatures only if applying for dependent coverage on a health plan from Kaiser Foundation Health Plan, Inc.)

X ______________________________

Applicant's spouse/Domestic partner **Today's date**

X ______________________________

Applicant/Dependent (age 18 or over) **Today's date**

X ______________________________

Applicant/Dependent (age 18 or over) **Today's date**

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (head of household, spouse/domestic partner, dependent). Parent or legal guardian must sign for dependents under the age of 18.

Use ink only.

For office use only:

Receive date: ______________________

❑ Accept ❑ Reject ❑ Rate ❑ Alternate

Process date: ______________________

Effective date: ______________________

MRN/HRN listed in Section III, page 3

Purch-EU/Grp-Sbgrp: ______________________

IX HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for KFHP Individuals and Families Plan coverage or KPIC insurance coverage but meet all of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements and only if your KFHP or KPIC application is declined. If you qualify for HIPAA coverage and applied for and qualify for KFHP coverage, we will enroll you in the KFHP plan. If you qualify for HIPAA coverage and applied and qualify for KPIC coverage, we will enroll you in the KPIC plan. For information about your HIPAA eligibility, plan benefits, and rates, or if you want to request a copy of a *Membership Agreement*, please call **1-800-464-4000**.

Questionnaire

Please read the HIPAA requirements below to determine whether all five are true statements for all family members applying for coverage. Then read the declarations on page 22 and check the appropriate response(s) for yourself (and any other family members). Your response(s) on page 22 will instruct Kaiser Permanente whether you or other family members wish to enroll in a HIPAA plan in the event you (or a family member) do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. *Creditable coverage* means continuous health coverage during the qualifying 18-month period immediately preceding this application for enrollment. If there have been multiple coverages during that qualifying period and/or a combination of individual and group coverage, a) there can be a break of no more than 63 days between coverages, and b) the final coverage must have been group coverage. For more information about the types of health coverage that may qualify for creditable coverage, please refer to your *Membership Agreement*, or call us at the information number listed above.
2. My most recent health coverage was through a group health plan, a governmental plan, or a church plan.
3. If I was eligible for continuation of coverage under federal (COBRA) or state (Cal-COBRA) laws, I enrolled in any available continuation coverage and paid all applicable premiums for the entire period for which I was eligible.
4. I do not currently have other health coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was not terminated for fraud or failure to pay premiums.

(continues on page 22)

IX HIPAA Eligibility Questionnaire and Request for Enrollment *(continued)*

Read the declarations below regarding the five statements listed on page 21. Then indicate which declaration is true for yourself and which declaration is true for each member of your family applying for coverage. **Check only one box for each family member applying.**

Print name(s). Use ink only.	All five statements are true. Enroll me in HIPAA if I do not qualify for a KFHP Individuals and Families plan or KPIC Individual plan.	All five statements are true. However, if I do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan, I do **not** want to be enrolled in HIPAA.	One or more of the five statements is false. I do not qualify for HIPAA.
Applicant	❑	❑	❑
Applicant's spouse/Domestic partner	❑	❑	❑
Applicant/Dependent (age 18 or over)	❑	❑	❑
Applicant/Dependent (age 18 or over)	❑	❑	❑
Applicant/Dependent (age 18 or over)	❑	❑	❑

If you selected a box in the first column, indicating that you (or a family member) want to be considered for HIPAA coverage, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Enrollment in HIPAA for yourself or a family member may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you (and/or family member[s]) will be enrolled for membership in HIPAA.

X

Applicant (Use ink only.) **Today's date**

Applicant's spouse/Domestic partner **Today's date**

Applicant/Dependent (age 18 or over) **Today's date**

Applicant/Dependent (age 18 or over) **Today's date**

Applicant/Dependent (age 18 or over) **Today's date**

Case ID: 216129