Kaiser Foundation Health Plan of Georgia, Inc. Kaiser Permanente Insurance Company (KPIC)

KAISER PERMANENTE®

Small Group Employee Enrollment and Change Form with Medical Review

Check One In Each Category:

❑ Enrollment Form ❑ Change Form

❑ HMO

❑ Multi-Choice ❑ with HSA Option ___ Self only ___ Family

❑ Out-of-Area PPO ❑ with HSA Option ___ Self only ___ Family

❑ Deductible Plan with HSA Option ___ Self only ___ Family

Check Box:	Fill Out Sections:
❑ Annual Enrollment	A, B, C, D
❑ Non-Annual Enrollment	A, B, C, D
❑ COBRA Enrollment	A, B, D, E
❑ Conversion	A, B, D, E
❑ Add Dependent(s)	A, B, C, D, E
❑ Termination of Subscriber (This will remove the entire family)	A, D, E
❑ Drop Dependents	A, B, D, E
❑ Change of Address	A, E
❑ Change Primary Care Provider	A, B, D, E
❑ Name Change	A, D, E
❑ Waive Coverage	A, D, E

To be Completed by Employer:

Effective Date

Group Number

Sub Group

Bill Group

A. Employee Information Note: Please use blue or black ink. Language preference: ________

EMPLOYEE

Last Name | First Name | MI | Gender ❑ M ❑ F | Marital Status ❑ Married ❑ Single

Employee Address | Date of Birth __-__-__ | Social Security Number ___-__-____

City | State | Zip Code | Home Phone ___-___-____ | Job Title

Company Name | Date of Employment __-__-__ | Hours Worked | Employment Status: ❑ Active ❑ Retired ❑ Disabled ❑ COBRA

Are you an independent contractor? ❑ YES ❑ NO

Consumer Choice Option (CCO)? ❑ YES ❑ NO *If yes, an additional premium will apply.* Ethnicity (optional): ____________

Please select Primary Care Physician Physician ID # ____ Check if you are an existing patient. ❑

Emergency Contact ____________ Phone ___-___-____

B. Coverage Status ❑ Self Only ❑ Self + Spouse ❑ Self + Spouse + Child(ren) ❑ Self + Child (ren)

SPOUSE

Last Name | First Name | MI

Date of Birth __-__-__ | Social Security Number ___-__-____ | Gender ❑ M ❑ F | Physician ID # | Check if you are an existing patient. ❑

CHILD

Last Name | First Name | MI

Date of Birth __-__-__ | Social Security Number ___-__-____ | Gender ❑ M ❑ F | Physician ID # | Check if you are an existing patient. ❑

College Student? ❑ YES ❑ NO School ____________ Disabled? ❑ YES ❑ NO

CHILD

Last Name | First Name | MI

Date of Birth __-__-__ | Social Security Number ___-__-____ | Gender ❑ M ❑ F | Physician ID # | Check if you are an existing patient. ❑

College Student? ❑ YES ❑ NO School ____________ Disabled? ❑ YES ❑ NO

CHILD

Last Name | First Name | MI

Date of Birth __-__-__ | Social Security Number ___-__-____ | Gender ❑ M ❑ F | Physician ID # | Check if you are an existing patient. ❑

College Student? ❑ YES ❑ NO School ____________ Disabled? ❑ YES ❑ NO

C. Health Questions

Applicants must complete this section. Please answer all questions completely and in ink. Sign and date any changes made or additional pages you may attach. If the answer to any of the following questions is "Yes," please provide details below. If you have questions, see your employer for assistance.

Note: Coverage is offered on a guaranteed acceptance basis. Medical information you provide cannot be used to deny coverage. However, accurate information about an applicant's health status is necessary for risk management purposes. Material misrepresentation or omission of information may be the basis for later rescision of health coverage.

	Name	Gender	Height/Weight	Current Physician (name/telephone)
Employee	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Child 1	_____	_____	_____	_____
Child 2	_____	_____	_____	_____
Child 3	_____	_____	_____	_____

All of the following questions must be answered with respect to each person applying for coverage. **Have you or any dependent to be covered EVER known of or have reason to know of, been diagnosed, had medical advice concerning, been seen or treated by a member of the medical profession for any of the following medical conditions? Check YES or NO.**

Answer questions 1-15 for groups enrolling 2-25 employees and late enrollees.
Answer questions 5-15 for groups enrolling 26-50 employees.

1. Arthritis, back, neck, or spinal injury, lupus, limb loss? ❑ YES ❑ NO
2. Asthma, emphysema, lung disorders, tuberculosis? ❑ YES ❑ NO
3. Epilepsy, stroke, or paralysis? ❑ YES ❑ NO
4. Sexually transmitted disease? ❑ YES ❑ NO
5. Mental, nervous, or compulsive disorders? ❑ YES ❑ NO
   Any substance abuse problem or rehabilitation? If yes, when _____ ❑ YES ❑ NO
   Alcoholism? ❑ YES ❑ NO
   Alcohol use: How many per week? _____ Abstinence (how long) _____
6. Autoimmune disease, or other condition or infection related to AIDS, HIV (within the last 10 years), or Hepatitis: type _____ ❑ YES ❑ NO
7. Bladder, kidney, liver, prostate, or reproductive disorders? ❑ YES ❑ NO
8. Blood disorders, Sickle Cell Anemia, or Diabetes: Fasting Blood Sugar reading: _____ ❑ YES ❑ NO
9. Cancer, tumors, thyroid, or glandular disorders? ❑ YES ❑ NO
10. Circulatory disorder, chest pain, heart disease, heart murmur, mitral valve prolapse, or high blood pressure? (last blood pressure reading _____) ❑ YES ❑ NO
11. Colitis, Crohn's Disease, diverticulitis, hernias, gall bladder disease, rectal disorders, or ulcers? ❑ YES ❑ NO
12. Currently pregnant or an expectant parent? If yes, due date _____ ❑ YES ❑ NO
13. Any hospitalizations in the past 5 years or any planned surgeries? ❑ YES ❑ NO
14. Current medications prescribed? ❑ YES ❑ NO
15. Any serious illness or disease not listed above? ❑ YES ❑ NO

By signing below, you verify that all questions have been answered correctly for all applying. (Another signature is also required on page 4 of this application.)

Signature of Primary Applicant _____ Date _____

If you checked yes to any of the above questions, please complete the following:

Question	Member	Diagnosis	Hospitalized	Treatment/ List all Medications	Dates	Is further treatment needed?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

D. Waiver of Coverage/Other Coverage Information

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 children

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 group coverage sponsored by another organization
❑ Other reason (please explain) _____
_____
_____

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 an *Employee Enrollment and Change Form*, and coverage may be subject to late enrollee provisions, as allowed by law.

Do you or any dependents have any other medical insurance? (check one) ❑ YES ❑ NO

Do you or any dependents currently receive Medicare benefits? (check one) ❑ YES ❑ NO

Insurance Company Name

Insurance Effective Date __-__-____

Policy Number

Insurance Company Address

Policy Holder

City

State

Zip Code

Policy Holder Date of Birth __-__-____

Who is covered?
❑ Self ❑ Spouse ❑ Family

If making a change from previous enrollment form, complete the following.

Effective Date: / /

❑ Termination of subscriber. Check reason for change:

- ❑ Quit
- ❑ Laid off
- ❑ Moved out of area
- ❑ Other _____
- ❑ Enrollment change
- ❑ Dissatisfaction

❑ Drop dependent(s). Check reason for change:

- ❑ Death: Date
- ❑ Divorce: Date
- ❑ Over age limit
- ❑ Other _____

❑ Add dependent(s). Check reason for change:

- ❑ Marriage: Date
- ❑ Birth: Date
- ❑ Adoption: Date
- ❑ Loss of coverage
- ❑ Other _____

❑ Change primary care provider

❑ Name change

Previous name:_____

Current name:_____

Effective date: _____

E. Please sign application on the reverse side of this form.

Please complete this application and submit it to your company's personnel office. I understand and agree that if the application is accepted by Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, my spouse, and dependents (if any) will be eligible will be in accordance with the Group Agreement and/or Group Policy, as applicable to the type of plan for which we are enrolled. 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 set forth in my employer's agreement with Health Plan, 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 such 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.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:
   a. The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.
   b. Any unmarried, dependent child of the subscriber or the subscriber's spouse, or an unmarried, dependent child who is claimed on the subscriber's federal tax return and is under the group's age limit for dependent status.

      If the dependent child has a different last name than the subscriber, please complete a Dependent Child Verification Form and attach it to this application.
2. Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Evidence of Coverage*.
3. Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.
4. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Customer Service at (404) 261-2590 before signing this application.

Personal Information

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. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Heath Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy. I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Heath Plan of Georgia, Inc., 3495 Piedmont Road, Atlanta, Georgia, 30305.

NOTICES:

1. I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failureto notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the recision 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, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.

2. You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; 3495 Piedmont Road NE; Building 9; Atlanta, GA 30305.

3. This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at *kp.org*. 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 Physician Directory, or obtain a list of current participating physicians and other providers by calling Customer Service at (404)261-2590.

4. HMO plans and the Kaiser Permanente Select Provider benefit level of the Multi- Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company.

IMPORTANT: Please read the conditions above, and sign and date below. All applications MUST be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

Signature of Primary Applicant	Date	E-mail Address (optional)