

**Section 1 – Instructions**

- **Do not include the first month's payment. If you're accepted, we will send you a bill.**
- Please use a **pen** to complete and sign this application.
- Make sure this application is complete and signed. Parents or legal guardians must sign for children under the age of 18. Applicants who are 15 years of age and older must sign the *Authorization to Obtain or Release Medical Information*. We are unable to process applications without appropriate signatures.
- If you would like help completing this application, please call **1-888-813-3700**. To be eligible for Kaiser Permanente Individuals and Families, you must live in our Oregon service area.
- **If this application contains any material misstatements or omissions, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

**Section 2 – Plan selection**

Choose one Kaiser Permanente Individuals and Families plan

<b>Copayment plans</b> <input type="checkbox"/> Platinum Rx <input type="checkbox"/> Platinum
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<b>Deductible plans</b> <input type="checkbox"/> Gold \$500 <input type="checkbox"/> Silver \$3,500 <input type="checkbox"/> Gold \$1,000 <input type="checkbox"/> Bronze \$5,000 <input type="checkbox"/> Silver \$1,500 <input type="checkbox"/> Bronze \$7,500 <input type="checkbox"/> Silver \$2,500
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<b>Deductible HSA plans</b> <input type="checkbox"/> \$1,500 Deductible/Rx with HSA Option <input type="checkbox"/> \$1,500 Deductible with HSA Option <input type="checkbox"/> \$2,600 Deductible/Rx with HSA Option <input type="checkbox"/> \$2,600 Deductible with HSA Option
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Additional information is available upon request.

 I would like to begin coverage on  the next available effective date  the 1st day of \_\_\_\_\_  
 (Please allow a minimum of 10 days for the processing of each completed application.) (cannot be more than **60 days** from date application signed)

 I am adding a new person to an existing Kaiser Permanente Individuals and Families account.

 Subscriber's health record number          
**Note:** Your plan options may be limited based on review of your application and medical history.

**Section 3 – Enrollment information**

 Complete the following information and submit one application for **each** family member **applying**:

<b>Applicant</b>	Last name	First name	Middle initial	Previous name(s)	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single
Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Social Security number	Health record number
Address			City	State	ZIP
Home phone			Work phone		

Names of other family members submitting applications (This helps us to process family members together.)

Spouse/ Domestic partner*	Last name	First name	Middle initial	Date of birth	Previous name(s)
Child					
Child					
Child					

\*A domestic partner is a person who has entered into a domestic partnership contract with another person of the same gender. Each person must be at least 18 years old and competent to enter into a contract, and at least one of them must be an Oregon resident

**For official use only**

Date received <input type="text"/>	<input type="checkbox"/> New account <input type="checkbox"/> Reapplication <input type="checkbox"/> Conversion <input type="checkbox"/> Upgrade <input type="checkbox"/> Add-on	Effective date _____ <input type="checkbox"/> Approved <input type="checkbox"/> Denied
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## Section 4 – Prior or current coverage

This coverage has a six-month waiting period for pre-existing conditions. This means that we do not pay for expenses incurred by you or your enrolled dependent(s) for pre-existing conditions during the six months following your or your enrolled dependent's effective date of coverage. A *pre-existing condition* is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the pre-existing condition waiting period, please provide responses to **all** the information requested below. For questions about waiting periods or pre-existing conditions, call **1-888-813-3700**. For questions about prior or current coverage, call **1-503-813-2000**.

### Details regarding current or prior coverage

1. Do you currently have insurance or have you had insurance in the past?
  - Yes
  - No
  
2. Name of insurance company \_\_\_\_\_  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_
  
3. Date coverage began \_\_\_\_\_  
 Date coverage ended/ends \_\_\_\_\_
  
4. Type of coverage:
  - Group plan
  - Church plan
  - Individual plan
  - OMIP
  - Health options plan
  - Federal plan  
(e.g., TRICARE, FEBHP, or Peace Corps Act)
  - Plan established/maintained by a foreign country or any political subdivision thereof
  - Plan of Indian Health Service or tribal organization
  - College, school, or short-term insurance
  
5. Deductible amount per year:  
 Individual \_\_\_\_\_  
 Family \_\_\_\_\_
  
6. Coinsurance \_\_\_\_\_
  
7. Coverage does or did include:
  - Maternity
  - Hospital only
  - Prescription drug
  - Waiting periods for organ transplants
  - None of the above
  
8. Names of individuals covered by current or prior insurer  
 \_\_\_\_\_  
 \_\_\_\_\_
  
9. Are you currently on or did you recently exhaust COBRA or state continuation coverage?
  - Yes
  - No
 If Yes, date coverage began \_\_\_\_\_  
 Date coverage ended \_\_\_\_\_
  
10. Are you eligible for the following?
 

Medicare Part A or B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

## Section 5 – Questionnaire

## Oregon standard health statement (Standard form per ORS 743.766)

All questions must be answered to begin processing. Please mark Yes or No for each item. Provide details in the health history details section (No. 55) to any questions answered Yes.

**(For the purpose of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.)**

**Notice to applicant:** You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Within the last 5 years, have you had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

- |   |  |   |  |
|---|--|---|--|
| 1. AIDS, ARC, HIV positive  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Chronic headaches/migraines   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/chemical/drug abuse/habit                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Heart/chest pain/angina   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Anemia/chronic fatigue   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Hernia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. High cholesterol<br>(if Yes, record last reading in No. 55)           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/neck/spine  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure<br>(if Yes, record last reading in No. 55)        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/congenital deformities                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/kidney stones  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/urinary tract  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/shoulder/hip/other joints  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/circulatory  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition/hepatitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/orthopedic  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. a. Mental/emotional condition/depression                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses)  | <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Therapy/counseling within last 5 years                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | (if Yes, record date of last session in No. 55)                           |  |
| 13. Chemotherapy/radiation treatment                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/disease/injury                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. a. Colon/rectum/intestine/bowel                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/blood clot  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Blood in stool   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/osteoporosis/osteopenia                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsions/seizures/epilepsy                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/elevated PSA/prostatitis                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/sugar in urine   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/infertility                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/nose/throat/tonsil condition/disease/disorder         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/lung condition                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited to, anorexia or bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid arthritis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/asthma/chronic lung disease (COPD)                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s)                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/gland/hormone system                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous moles, or eczema/cysts/cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of eye/cataract/glaucoma                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 22. Gallbladder/pancreatic disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

*(continues on page 4)*

**Note: All questions must be answered to begin processing.**

**Section 5 – Questionnaire** *(continued)*

**Oregon standard health statement**  
**(Standard form per ORS 743.766)**

42. Sleep apnea/chronic sleep disorder  Yes  No
43. Stomach disorders/ulcer/acid reflux  Yes  No
44. Stroke/paralysis/seizures  Yes  No
45. Tumors  Yes  No
46. TMJ/jaw joint  Yes  No
47. Weight fluctuation (+/- 20 lbs.)  Yes  No
48. Cosmetic surgery/implants, use of prosthetic devices/limbs  Yes  No
49. a. Have you used tobacco products in any form within the last 5 years?  Yes  No  
 b. If Yes, please list each type of product(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
50. For females only—please provide the following information:  
 a. Initial menstrual cycle begun?  Yes  No  
 b. Date of last menstrual period \_\_\_/\_\_\_/\_\_\_  
 c. If (b) is more than 35 days ago, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 d. Excessive or absent menstrual bleeding?  Yes  No  
 e. If (d) is Yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 f. Date of last Depo-Provera shot \_\_\_/\_\_\_/\_\_\_  
 g. Abnormal Pap smears?  Yes  No  
 h. Prior cesarean section or miscarriage?  Yes  No
51. a. Are you currently pregnant?  Yes  No  
 b. If Yes, due date \_\_\_/\_\_\_/\_\_\_
52. a. Are you (including male applicants and dependent males or females) responsible for a current pregnancy?  Yes  No  
 b. If Yes, due date \_\_\_/\_\_\_/\_\_\_
53. Within the last 5 years, have you:  
 a. Had any medical advice, diagnosis, care, or treatment (including prescribed medications) recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement not listed above?  Yes  No  
 b. Had chronic cough, fatigue, diarrhea, or enlarged glands?  Yes  No  
 c. Been advised to have or contemplated having an operation or medical procedure not yet performed?  Yes  No  
 d. Been scheduled to see a health care provider?  Yes  No  
 e. Taken any prescription medication on a regular basis?  Yes  No

54. List all medications you are currently taking:

Medications	Prescribed by (name/address/telephone)	Date prescribed

55. Please provide specific details below to any questions answered Yes on the previous pages.

Question no.	Dates	Condition	Treatment	Final result

Do you have Medicare or Medicaid coverage?  Yes  No

If you're accepted, who will be paying the monthly premiums? Relationship to applicant:  Self  Spouse/Domestic partner  Parent

Last name	First name	Middle initial
Address		
City	State	ZIP
Home phone	Work phone	

**Section 6 – Certification/Authorization**

**Certification of completion and correctness**

By completing this application, I affirm that the answers given in this *Oregon Standard Health Statement* are complete and correct. I am providing these answers as part of the application procedure required by this health care service contractor to enroll in its health plan. I understand that if this application contains any material misstatements or omissions, the health care service contractor may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform the health care service contractor in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the health care service contractor. If approved, coverage will be in force as of the effective date determined by the health care service contractor. The health care service contractor may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

**X** \_\_\_\_\_  
Applicant's signature

**Producer authorization  
(if you are working with a health insurance producer)**

I (the member) authorize the insurance producer listed below to share enrollment, disenrollment, and summary plan information specific to this application with the health care service contractor.

I understand that the insurance producer of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Northwest (KFHPNW) in connection with the purchase of this health plan coverage.

**X** \_\_\_\_\_  
Applicant's signature

I (the producer) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written materials furnished by KFHPNW. The applicant has been informed that the effective date of coverage is assigned by KFHPNW. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

\_\_\_\_\_  
Agency name

\_\_\_\_\_  
Agency number

\_\_\_\_\_  
Producer's name

**X** \_\_\_\_\_  
Producer's signature

## Authorization to obtain or 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 Kaiser Foundation Health Plan of the Northwest product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan of the Northwest or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente producer, 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, HIV [human immunodeficiency virus] status, AIDS [acquired immune deficiency syndrome], or ARC [AIDS related complex]**). 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 also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize Kaiser Foundation Health Plan of the Northwest to disclose to my insurance producer 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 the 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, HIV/AIDS- or ARC-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claim for benefits for an Applicant if that Applicant is still a member of Kaiser Foundation Health Plan of the Northwest. A photocopy of this authorization is as valid as the original, and I and my Kaiser Permanente producer are entitled to receive a copy of this form.

I may revoke this authorization (to the extent applicable to my Medical Information) at any time prior to its expiration. However, revocation is not effective to the extent that Kaiser Permanente has already taken action in reliance on it, or for so long as Kaiser Permanente may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's *Notice of Privacy Practices*.

<b>X</b>		
Primary applicant/Parent or legal guardian	Today's date	Date of birth

<b>X</b>		
Applicant's spouse/Domestic partner	Today's date	Date of birth

<b>X</b>		
Applicant (age 15 or over)	Today's date	Date of birth

**Signatures (required)**

**Important:** All Applicants age 18 or over must sign and date above on the appropriate signature line (Primary applicant/Parent or legal guardian, Applicant's spouse/domestic partner). A parent or legal guardian must sign for dependents under the age of 18. In addition, all Applicants age 15 or over must sign and date above on the designated signature line.

**Use black ink only.**

**Please read and sign in all the places noted and photocopy for your records.  
We will be unable to process your application without your signature.**

**(intentionally blank)**

**Kaiser Permanente Individuals and Families (8539)  
P.O. Box 7104  
Pasadena, CA 91109**

