

MEMBERSHIP APPLICATION FOR

Kaiser Permanente Personal Advantage

You or your authorized representative may request a copy of your completed application. For more information, please call (404) 364-7001.

NOTE: Applications are subject to medical review, and must be dated within 60 days of your requested effective date. Your payment must be received prior to final processing. This application may become part of your permanent medical record if your membership is approved. It may be reviewed again by you with a physician.

INSTRUCTIONS:

- Please answer all questions completely to ensure timely processing of your application.
- Use only black or blue ink.
- Completely fill in the **O** bubbles. *Example: **O***
- Print clearly above the lines or inside the boxes.
- Remember to sign the Application Agreement (page 6), complete the Payment Options section (page 7), and include a check for the first month's premium (unless paying by credit card).
- If you choose to apply for a Kaiser Permanente *Balance Plan*, please complete the *Balance Plan Acknowledgement Form* attached to page 2 of this application.*

*NOTE ABOUT **BALANCE PLANS**: This application includes an option to apply for an Alternative Health Benefit Plan, called Kaiser Permanente Balance Plans. These plans do not provide all of the state mandated health benefits normally required in accident and sickness insurance policies in Georgia. The Balance plans may provide a more affordable health insurance policy for you, although, at the same time, they may provide you with fewer health benefits than those normally included as state mandated health benefits in policies in Georgia. If you choose a Balance plan, please consult with your insurance agent to discover which state mandated health benefits are excluded in this policy.

For a complete listing of available physicians, visit kp.org.

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736



1. PERSONAL INFORMATION — PRIMARY APPLICANT

As the oldest person applying for coverage, I am the primary applicant and hereby apply for membership in Kaiser Permanente based on the following:

Select One: Mr. Mrs. Ms. Miss Dr.
 Marital Status: Single Married Widowed Divorced

| | | | | | | | | |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|
| Last Name | First Name | MI | Social Security # - - | Birthdate MM/DD/YY | Height (ft./in.) | Weight (lbs.) | Sex M/F | Prior HRN* |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|

Street Address (cannot be a P.O. Box) _____ Apt. # _____

City _____ State _____ ZIP Code _____

Home Phone _____ Work Phone _____ E-mail Address _____

Is the billing address different than the address listed above? Yes No
 If Yes, please list the billing address below:

Billing Street Address _____ Apt. # or P.O. Box _____

City _____ State _____ ZIP Code _____

Please complete the following information for each additional person applying. If more space is needed for additional applicants, please attach another application and complete just the information for those additional applicants. (You can print another application from our Web site, kp.org/care.)

Spouse

| | | | | | | | | |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|
| Last Name | First Name | MI | Social Security # - - | Birthdate MM/DD/YY | Height (ft./in.) | Weight (lbs.) | Sex M/F | Prior HRN* |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|

Dependent 1 (D1) Relationship - Son Daughter Other (_____)

| | | | | | | | | |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|
| Last Name | First Name | MI | Social Security # - - | Birthdate MM/DD/YY | Height (ft./in.) | Weight (lbs.) | Sex M/F | Prior HRN* |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|

Dependent 2 (D2) Relationship - Son Daughter Other (_____)

| | | | | | | | | |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|
| Last Name | First Name | MI | Social Security # - - | Birthdate MM/DD/YY | Height (ft./in.) | Weight (lbs.) | Sex M/F | Prior HRN* |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|

Dependent 3 (D3) Relationship - Son Daughter Other (_____)

| | | | | | | | | |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|
| Last Name | First Name | MI | Social Security # - - | Birthdate MM/DD/YY | Height (ft./in.) | Weight (lbs.) | Sex M/F | Prior HRN* |
|-----------|------------|----|--------------------------|-----------------------|---------------------|------------------|------------|------------|

* Prior Kaiser Permanente Health Record Number (HRN), if applicable.

For Office Use Only:

BROKER NAME: _____
 AGENT #

General Agency Stamp (if applicable)

2. PLAN SELECTION

a) Which plan are you applying for?

HMO Plans

- Premier Plan
- Plan 500
- Plan 1,000
- Plan 2,000
- Plan 3,000
- Plan 5,000

Custom Care HealthInvestor (HSA)

- HSA Option 3,500/100% Self
- HSA Option 5,000/100% Self
- HSA Option 3,500/80% Self
- HSA Option 3,500/100% Family
- HSA Option 5,000/100% Family
- HSA Option 3,500/80% Family
- HSA Option 5,000/80% Family

Balance Plans

If selecting one of the plan choices below, you are required to sign the acknowledgment form, found on the attached page. This acknowledgement form MUST be signed in order to apply for any of the plan choices listed below.

Balance HMO Plans

- Balance HMO 2,000
- Balance HMO 3,000
- Balance HMO 5,000
- Balance HMO 7,500
- Balance HMO 10,000

Balance HealthInvestor (HSA) Plans

- Balance HSA 1,200/100%
- Balance HSA 2,000/80%

b) Requested Effective Date of Coverage Month _____ Day 01 Year _____

The earliest your coverage will begin is the first of the month following receipt of a completed application and first month's premium. Coverage will not be back-dated.

What type of coverage are you applying for? (Select only one.)*

- Individual
- Individual & Spouse
- Individual & Child(ren)
- Family (Individual, Spouse, & Child(ren))

* If you are applying for a Kaiser Permanente Personal Advantage Balance plan, select "Individual" coverage. Each member of your family accepted for coverage will be enrolled in individual coverage. Dependent and family coverage are not available in the Balance plans.

Has any applicant ever been a Kaiser Permanente member? Yes No

If Yes, please be sure you have written their prior Kaiser Permanente Health Record Number (HRN), if known, in their "Prior HRN" box on the page 1.

Type of Application:

- Addition of a family member to an existing Kaiser Permanente member's coverage
- New coverage

Existing member's Health Record Number (HRN) _____

What if all family members are not accepted?

Please remember that Kaiser Permanente's Personal Advantage plans are individually underwritten. Each family member must pass a medical review. It is possible that some or all family members may not be accepted. In the event that all family members are not accepted, please instruct us how to handle accepted family members:

- Please enroll any accepted family members.
- Please cancel the enrollment process for any accepted family members and return my first month's premium check.

BALANCE PLAN ACKNOWLEDGEMENT FORM

For Balance Plan Applicants Only

If you are applying for a Kaiser Permanente Balance Plan, please read the following notice. If you are applying for any other type of plan, this notice does not apply, and you may simply disregard it.

In order to be enrolled in a Kaiser Permanente Balance Plan, you **MUST** sign the reverse side of this *Balance Plan Acknowledgement Form* and return it with this application. Failure to sign the form will delay your Kaiser Permanente enrollment.

Please also note that Balance plans offer individual coverage only. If your spouse and/or child(ren) would like to be enrolled in a Balance plan, they must each submit their own separate application, which will be subject to medical screening. If you need additional applications, you can print them out from our Web site, kp.org/care.

PERFORATION (DO NOT PRINT)

BALANCE PLAN ACKNOWLEDGEMENT FORM

For Balance Plan Applicants Only

If you are applying for a Kaiser Permanente Balance Plan, please read and sign the notice below. (If you are applying for any other type of plan, you may simply disregard this notice.)

Acknowledgement of Limited Benefit Coverage

In choosing one of Kaiser Permanente's Balance Plans, I understand that these plans do not provide coverage for some state mandated benefits. The following is a comparison of benefits provided under Kaiser Permanente Personal Advantage HMO plans that are either not covered or are significantly different under the Balance plans. If you have any questions about comparison of benefits between Personal Advantage HMO plans and the Balance plans, please call us at **1-800-232-4404** before you sign.

| Benefit | Personal Advantage HMO Plans | Personal Advantage Balance Plans |
|---|-------------------------------------|---|
| Maximum Benefit While Covered | Unlimited | \$3,000,000 |
| Maternity Services— (all services related to prenatal, postnatal, and delivery care) | Covered | No coverage |
| Infertility Diagnosis | Covered | No coverage |
| Vision Exams | Covered | No coverage |
| Dental Care— accidental injury | Covered | No coverage |
| Dental Care— Non-surgical dental treatment for TMJ, including dental splints | Covered | No coverage |

I have read and understand the comparison of benefits between the plans being offered to me, and I understand the benefit limitations and exclusions of the Kaiser Permanente Balance plans.

Signature _____ Date _____

Printed Name _____

3. MEDICAL INFORMATION

- Answer the questions below with respect to yourself and each family member applying for coverage.
- If you can answer Yes for any applicant, fill in the Yes bubble and explain further—for each person the Yes applies to—on the chart in Question 8.

Have you or any family member applying for coverage:

1. been hospitalized in the last 12 months, except for pregnancy?

Yes No

2. required medical attention 6 or more times in the last 12 months, except for pregnancy?

Yes No

3. within the last 3 years, been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?

Yes No

4. in the last 5 years, taken or used illegal drugs or prescription drugs not prescribed by a doctor?

Yes No

5. in the last 5 years, participated in or been advised to participate in a program that deals with your alcohol or substance abuse?

Yes No

6. ever been treated for, or had a doctor or other health care provider advise you that you have, any of the following conditions?

Please mark all that apply.

- AIDS, ARC, HIV
- Sexually transmitted disease
- Hepatitis
- Hernia not repaired
- Back/neck pain or injury
- Bone marrow transplant
- Crohn's or ulcerative colitis
- Depression or anxiety
- Mental health condition
- Eating disorder, anorexia nervosa/bulimia
- Heart or valve condition
- Asthma
- Emphysema/COPD
- Lung condition, other chronic condition
- High blood pressure
- High cholesterol
- Kidney/bladder condition — including kidney stones
- Liver condition or pancreas disorder
- Gallstones
- Anemia or other blood disorder

Painful or irregular menstrual cycle or female reproductive disorders

Lupus/SLE/inflammatory condition

Breast implants

Melanoma/breast/prostate/bladder cancer

Skin cancer

Other cancers

Aneurysm

MS/ALS/Parkinson's/Alzheimer's

Neurologic condition

Pacemaker or other implanted medical device

Prostate condition

Rheumatoid arthritis

Seizures/headaches requiring medical treatment

Sickle cell anemia

Diabetes

Stomach or intestinal problems or GI reflux

Stroke

Lumps, masses, tumors, or growths

Ulcer

Other conditions not specifically listed on application, even if not currently under treatment

None of the above

7. experienced unexplained and/or undiagnosed symptoms such as the following? Please mark all that apply.

Fever

Rectal bleeding

Swollen glands

Loss of appetite

Chest pain

Dizziness

Shortness of breath

Chronic fatigue

Abdominal or pelvic pain

Rash/skin problems

Loss of consciousness

Skin lesions

Unexplained weight loss

Lumps

Other _____

None of the above

Answer the questions below for yourself and each family member applying for coverage. (D1, D2, and D3 should correspond to the Dependents you listed under Additional Applicants in the Personal Information section.) Choose the one most appropriate answer for each person applying and mark an **X** in that box. Write in numeric answers when asked.

10. (a) If you have ever smoked cigarettes, what is or was your average daily usage?

| | Self | Spouse | D1 | D2 | D3 |
|-----------------|------|--------|----|----|----|
| ½ pack or less | | | | | |
| 1 pack | | | | | |
| 1½ packs | | | | | |
| 2 or more packs | | | | | |
| N/A | | | | | |

(b) For how long?

| | Self | Spouse | D1 | D2 | D3 |
|-----------------|------|--------|----|----|----|
| 9 years or less | | | | | |
| 10-14 years | | | | | |
| 15-19 years | | | | | |
| 20-29 years | | | | | |
| Over 30 years | | | | | |
| N/A | | | | | |

(c) Have you quit?

| | Self | Spouse | D1 | D2 | D3 |
|--------------|-------|--------|-------|-------|-------|
| Yes | | | | | |
| No | | | | | |
| If so, when? | MM/YY | MM/YY | MM/YY | MM/YY | MM/YY |

11. (a) Have you consumed more than 10 alcoholic beverages per week within the last 6 months?

| | Self | Spouse | D1 | D2 | D3 |
|-----|------|--------|----|----|----|
| Yes | | | | | |
| No | | | | | |

(b) If Yes for 11 (a), write in the number of drinks consumed weekly.

| | Self | Spouse | D1 | D2 | D3 |
|-------------|------|--------|----|----|----|
| Beer | | | | | |
| Wine | | | | | |
| Hard liquor | | | | | |

12. Are you an expectant parent or do you have a pending adoption?

| | Self | Spouse | D1 | D2 | D3 |
|-----|------|--------|----|----|----|
| Yes | | | | | |
| No | | | | | |

13. Are you currently taking birth control medication, estrogen, Premarin, Depo-Provera, etc.?

| | Self | Spouse | D1 | D2 | D3 |
|-----|------|--------|----|----|----|
| Yes | | | | | |
| No | | | | | |

14. For females over age 11 only:

(a) Are you pre-menstrual (have never menstruated), post-menopausal, or have you had a hysterectomy or tubal ligation?

| | Self | Spouse | D1 | D2 | D3 |
|-----|------|--------|----|----|----|
| Yes | | | | | |
| No | | | | | |

(b) If No, date of your most recent normal menstrual period:

| Self | Spouse | D1 | D2 | D3 |
|----------|----------|----------|----------|----------|
| MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY |

For Office Use Only:

Underwriter _____ Effective Date _____

Primary _____ Spouse _____ D1 _____ D2 _____ D3 _____

4. APPLICATION AGREEMENT

I hereby apply for enrollment for myself and eligible family dependents listed on this form, and I agree that the information listed is correct. Upon acceptance to the Health Plan, my enclosed check for the first month's premium will be deposited or my credit card charged, and my coverage will begin on the first day of the month as assigned by Health Plan.

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 me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product (each, an "Applicant") to give Kaiser Foundation Health Plan of Georgia, Inc., or its affiliates ("Kaiser Permanente"), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, 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) ("Medical Information") of the Applicant. 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 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 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 any Kaiser Foundation Health Plan. 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. I may revoke this authorization (to the extent applicable to my Medical Information)

I authorize the disclosure of premium billing, claim payment, and commission information to my broker of record and my spouse (if applicable) to expedite the servicing of my account. Yes No

| | |
|--|--|
| | |
|--|--|

Signature of Primary Applicant

Date

| | |
|--|--|
| | |
|--|--|

Signature of parent or guardian if Primary Applicant is under 18

Date

| | |
|--|--|
| | |
|--|--|

Signature of Spouse

Date

| | |
|--|--|
| | |
|--|--|

Signature of Dependent if 18 years of age or older or emancipated minor

Date

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

NOTICES:

1. Any intentional material misstatement or omission of information may void your coverage and/or the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

2. YOU MUST IMMEDIATELY INFORM US if your health status or current medication changes at any time before your membership in Personal Advantage becomes effective. Failure to inform us of such changes can void your membership. You can choose to update your application information by telephone (404) 364-7001 (option 2), by fax (404) 365-4146, or by writing us at Kaiser Permanente Personal Advantage; 3495 Piedmont Road, NE; Building 9; Atlanta, GA 30305. All written and fax correspondence must be signed and dated.

3. After the effective date of this coverage, Health Plan may rescind your coverage and your dependent's coverage retroactively to the effective date (1) based on updated information, (2) upon learning that you failed to provide updated information, OR (3) upon learning that you intentionally provided any incorrect or incomplete answers on this application or in communications regarding it. If your coverage is rescinded, you will be billed for all services you received.

4. Georgia residents who do not qualify for Personal Advantage and are not current Kaiser Foundation Health Plan members may be eligible to participate in the State of Georgia Health Insurance Assignment System, a state-sponsored guaranteed-issue health care coverage program in which Kaiser Permanente participates. For more information, call 1-800-656-2298. Georgia residents who do not qualify for Personal Advantage and who are current Kaiser Foundation Health Plan members can choose to be considered for our conversion products, one of which is available to HIPAA-qualified individuals. If you wish to exercise that option, please contact our Customer Service Department at (404) 261-2590 to obtain an application.

IMPORTANT: Please read the conditions above, and sign and date below. **All applications MUST be signed and dated by Primary Applicant, Spouse (if applicable), and any Dependent 18 years of age or older (if applicable). I have read and understand all of the above conditions and terms.**

5. PAYMENT OPTIONS

- Automatic Draft Plan*** Your most convenient and reliable option is this payment method. Payments are automatically deducted from your checking or savings account between the first and the fifth day of each month. To enroll, simply read and fill out the section below. **BE SURE TO INCLUDE A VOIDED CHECK AND YOUR FIRST MONTH'S PREMIUM.**

**Note: If you choose the Automatic Draft Plan as your payment option, you are still required to send a check for your first month's premium and a voided check. The automatic draft plan takes effect in your second month of coverage.*

I hereby authorize Kaiser Foundation Health Plan of Georgia, Inc., (Health Plan) to debit my checking or savings account with the financial institution named below. If a debit will differ from that of the previous month's debit, Health Plan will notify me in writing at least seven days in advance of the change.

This authority is to remain in full force and effect until Health Plan has received written notification from me of its termination in such time and in such manner as to afford Health Plan reasonable opportunity to act on it. (Must give Health Plan 30 days.)

If an entry is erroneously initiated by Health Plan to my account, I have the right to have the amount of the entry credited to my account. However, I must give the financial institution a written notice within 15 days explaining that the entry was in error.

Bank Name: _____ Member (Depositor) Account Number: _____

Bank Address: _____ Type of account (check one) Savings Account Other
 Checking Account
(Please attach a voided check)

Member Name(s): _____
(Please Print)

Signed: _____
(Member Signature)

Date: _____ Signed: _____
(Depositor Signature)

Date: _____ Signed: _____
(2nd Depositor Signature if Joint Account)

- Payment by Credit Card** Your credit card will be charged for your/your family's first month's premium. Also, each month's premium will be automatically charged to your credit card on the 20th of the month prior unless you arrange another form of payment by calling (404) 364-7179. Your credit card will be charged only if you are accepted for membership.

Type of card: _____ Credit card number: _____ Expiration date: _____

Name as it appears on card: _____ Signature: _____

- Payment by Monthly Invoice*** You will receive a monthly invoice from Kaiser Permanente. Payment is due on or before the first day of each month. If payment is not received by this date, you are subject to termination of membership.

**Note: If you choose the Payment by Monthly Invoice option, you are still required to send your first month's premium.*

If you do not choose a payment method, you will automatically receive a monthly invoice. You are still required to send your first month's premium.