HEALTHSPAN | *Care and Coverage formerly by Kaiser Permanente*

Kaiser Permanente Insurance Company

OHIO REGION
Employee Enrollment/Change Form

TO BE COMPLETED BY EMPLOYER/GROUP ONLY

EMPLOYER/GROUP NAME _____ EFFECTIVE DATE (MM/DD/YYYY) ____ / ____ / _____

GROUP NO _____ SUBGROUP NO _____ BILLGROUP _____ DATE OF HIRE (MM/DD/YYYY) ____ / ____ / _____

Enrollment/Change Reason (Please check one.) Event Date (MM/DD/YYYY) ____ / ____ / _____

☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Loss of Coverage

☐ Existing Group ☐ Newborn ☐ Term ☐ COBRA ☐ Other _____

If you have purchased a HealthSpan Financial Account to be paired with your health plan, please check one:

☐ Health Reimbursement Arrangement (HRA) ☐ Health Savings Account (HSA)

☐ Flexible Spending Account (FSA) ☐ Stacked HRA/FSA

SECTION 1A: TYPE OF PLAN (PLEASE CHECK ONE)

☐ HMO PLAN _____ ☐ ADDED CHOICE (POS) PLAN*

☐ HMO DEDUCTIBLE PLAN _____ ☐ ADDED CHOICE (POS) DEDUCTIBLE PLAN*

☐ HMO HIGH DEDUCTIBLE HEALTH PLAN ☐ OUT-OF-AREA (PPO)

When choosing your primary care physician for HMO or POS please use the HMO/Tier One Provider Directory.

*Mid and Large Group Only

Do you have an aggregate deductible? ☐ YES ☐ NO

SECTION 1B: TYPE OF SIGNATURE PLAN (PLEASE CHECK ONE)

☐ SIGNATURE HMO PLAN ☐ SIGNATURE (POS) PLAN*

☐ SIGNATURE HMO DEDUCTIBLE PLAN ☐ SIGNATURE (POS) DEDUCTIBLE PLAN*

☐ SIGNATURE HMO HIGH DEDUCTIBLE HEALTH PLAN

When choosing your primary care physician for Signature HMO or POS plans please use the Signature HMO/Tier One Provider Directory.

*Mid and Large Group Only

Do you have an aggregate deductible? ☐ YES ☐ NO

SECTION 2A: SUBSCRIBER/EMPLOYEE INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ Apartment Number _____

City _____ State _____ Zip Code _____ Home Phone ___ - ___ - ____

Date of Birth (MM/DD/YYYY) ____ / ____ / _____ Male ☐ Female ☐ Social Security Number ___ - ___ - ____ MRN _____ - ____ - ____

Primary Care Physician (PCP) Name: _____ PCP ID Number: _____

YOU MUST CHOOSE A PCP IN ORDER TO COORDINATE CARE FOR ALL HMO AND POS PLANS.

SECTION 2B: PRIOR COVERAGE

Are you a former member of a Kaiser Foundation Health Plan of Ohio, prior to 10/1/2013? ☐ YES ☐ NO

If so, do you know your Medical Record Number? ☐ YES: _____ - ____ - ____ ☐ NO

If you were a member under a different name at that time, please provide the name:

Last Name _____ First Name _____ MI _____

EMPLOYEE LAST NAME ______________________ SOCIAL SECURITY NUMBER ______ - ____ - ______

SECTION 3: FAMILY / DEPENDENT INFORMATION

Complete this section for each eligible dependent you wish to enroll/disenroll for the Plan Year (do not list yourself). Attach a separate sheet if you need more space.

Add ☐ Delete ☐ MRN ________ - ____ - ____

Last Name ______________________ First Name ______________________ MI ____

Date of Birth (MM/DD/YYYY) ___ / ___ / ______ Male ☐ Female ☐ Social Security Number ______ - ____ - ______

Relationship to Subscriber ______________________ Disabled?: Yes ☐ No ☐

Primary Care Physician (PCP) Name: ______________________ PCP ID Number: ______________

YOU MUST CHOOSE A PCP IN ORDER TO COORDINATE CARE FOR ALL HMO AND POS PLANS.

Add ☐ Delete ☐ MRN ________ - ____ - ____

Last Name ______________________ First Name ______________________ MI ____

Date of Birth (MM/DD/YYYY) ___ / ___ / ______ Male ☐ Female ☐ Social Security Number ______ - ____ - ______

Relationship to Subscriber ______________________ Disabled?: Yes ☐ No ☐

Primary Care Physician (PCP) Name: ______________________ PCP ID Number: ______________

YOU MUST CHOOSE A PCP IN ORDER TO COORDINATE CARE FOR ALL HMO AND POS PLANS.

Add ☐ Delete ☐ MRN ________ - ____ - ____

Last Name ______________________ First Name ______________________ MI ____

Date of Birth (MM/DD/YYYY) ___ / ___ / ______ Male ☐ Female ☐ Social Security Number ______ - ____ - ______

Relationship to Subscriber ______________________ Disabled?: Yes ☐ No ☐

Primary Care Physician (PCP) Name: ______________________ PCP ID Number: ______________

YOU MUST CHOOSE A PCP IN ORDER TO COORDINATE CARE FOR ALL HMO AND POS PLANS.

Add ☐ Delete ☐ MRN ________ - ____ - ____

Last Name ______________________ First Name ______________________ MI ____

Date of Birth (MM/DD/YYYY) ___ / ___ / ______ Male ☐ Female ☐ Social Security Number ______ - ____ - ______

Relationship to Subscriber ______________________ Disabled?: Yes ☐ No ☐

Primary Care Physician (PCP) Name: ______________________ PCP ID Number: ______________

YOU MUST CHOOSE A PCP IN ORDER TO COORDINATE CARE FOR ALL HMO AND POS PLANS.

EMPLOYEE LAST NAME _____ SOCIAL SECURITY NUMBER ___ - ___ - ____

SECTION 4: OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed in sections 2 and 3 above have other coverage?

☐ Yes ☐ No If yes, please provide the following information: _____

Name of Insured: _____ Relationship: _____

Name of Insurance Company: _____ Telephone Number ___ - ___ - ____

Policy/Group Number: _____

OTHER INSURANCE: MEDICARE

List below, yourself and any other dependents to be covered who are eligible for Part A and/or Part B of Medicare:
(Attach a seperate sheet if more space is needed)

Last Name _____ First Name _____ MI ____

Medicare Claim Number ___ - ___ - ____ ___ Entitled Due To: _____

Effective Date	Part A (MM/DD/YYYY)	Age	Disability	Renal Disease
	____ / ____ / _____	_____	☐	☐
Effective Date	Part B (MM/DD/YYYY)	Age	Disability	Renal Disease
	____ / ____ / _____	_____	☐	☐

SECTION 5: AUTHORIZATION AND SIGNATURE FOR ENROLLMENT

IMPORTANT: YOUR APPLICATION CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE. PLEASE READ THE BACK OF THIS FORM BEFORE SIGNING.

Note: I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions as described in section 6 on the back of this page. I understand that knowingly furnishing incorrect or incomplete information or failing to notify Health Plan of changes in eligibility status will result in termination of membership of my coverage and all Dependents' or the offending Dependent's coverage, upon [0-15] days written notice from Health Plan.

Applicant Signature _____ Date ____ / ____ / _____

SECTION 6: TERMS CONDITIONS AND AUTHORIZATIONS

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

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

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

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

I, my spouse, and my dependents (if any) listed in Section 3 of this application understand that we are entitled to receive a copy of this application.

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

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

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

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