



KAISER PERMANENTE®

Child Health Plan Application

Instructions:

- The non-covered Subscriber (Applicant) should complete and sign this application. You are the Applicant if your name is identified with the family's account and if you are responsible for the account. On this form, "you" and "your" refer to the Applicant.
- Please answer each question; incomplete applications cannot be processed and will be denied.
- Inaccurate answers may result in termination of your child(ren)'s coverage.
- Please provide copies of the most current proof of monthly income or your application will be denied.
- Please complete the Profit and Loss Statement, if applicable.
- Make a copy of your completed application to keep for your records.
- Fill out the enclosed postcard and send it in with your completed application.
- Please note that it may take at least **45 business days** to process your application.
- Completion of this application does not guarantee enrollment in Kaiser Permanente Child Health Plan.

**PLEASE DO NOT SEND PERSONAL CHECKS,
MONEY ORDERS, OR CASH WITH THIS APPLICATION.**

1. Tell us about the person applying for the child(ren).

Mrs. Ms. Mr.

Last Name	First Name	Middle Initial
------------------	-------------------	-----------------------

Date of Birth: _____ / _____ / _____
month day year

Gender Male Female

Marital Status: Single Married Domestic Partner
 Divorced Separated Widowed

Child(ren)'s Home Address (if different from mailing/billing address) **(Do not use P.O. Box)** Apt. No. City State ZIP Code

Mailing/Billing Address (person responsible for the bill) **(P.O. Box acceptable)** Apt. No. City State ZIP Code

Daytime Telephone Number Evening Telephone Number

Have you ever been a Kaiser Permanente member? Yes No

If you were a previous Kaiser Permanente member under a different name (for example: maiden or married name), what name did you use? _____

Kaiser Permanente Medical Record Number (if available) **Social Security Number (optional)**

I prefer to receive materials in: English Spanish

Race (optional): African American Asian/Pacific Islander
 Latino Caucasian Other _____

2. How did you hear about this program?

- Kaiser Permanente Member Service Call Center
 - Web site
 - Ad in the mail
 - Kaiser Permanente staff
 - Friend or relative
 - Other _____
- Community Agency (Name of Agency) _____

Name of Assister	Please provide your KP EE number KP EE # _____ Internal Use Only	Telephone Number
------------------	---	------------------

3. What is the total number of people living in your home that you claim as a dependent, including yourself? _____

4. Tell us about the child(ren) under age 19 for whom you are applying.

If additional space is needed to list more children, photocopy page 2 of this application and attach it. Answer all questions on the photocopied page or the application will be denied.

	Child (1)	Child (2)	Child (3)	Child (4)
Last Name				
First Name				
Middle Initial				
Date of Birth: month/day/year	/ /	/ /	/ /	/ /
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number (optional)				
Relationship to Person Applying				
Kaiser Permanente Medical Record Number (if available)				

Questions 5, 6, and 7 only apply to children listed under question 4. PLEASE ANSWER EACH QUESTION.

5. Does your child(ren) qualify for *No-Cost Medi-Cal coverage or Healthy Families?*

Yes No If "yes," please list their names:

_____	_____
Name	Name
_____	_____
Name	Name

6. Is your child(ren) covered by other health coverage? (for example: from an employer, Medi-Cal, Healthy Families, or CCS [California Children's Services])

Yes No If "yes," please list their names and the date health coverage ends:

_____	_____	_____	_____
Name	Date health coverage ends	Name	Date health coverage ends
_____	_____	_____	_____
Name	Date health coverage ends	Name	Date health coverage ends

7. Does an employer offer to pay all or some portion of your child(ren)'s health coverage?

Yes No If "yes," please list their names and the date their health coverage ends:

_____	_____	_____	_____
Name	Date health coverage ends	Name	Date health coverage ends
_____	_____	_____	_____
Name	Date health coverage ends	Name	Date health coverage ends

Third Party Authorization (if applicable)

If you wish to give us permission to speak about your case with someone other than yourself, you must:

Complete the "Permission to share information with the following person" section below, by telling us the name and relationship (for example: spouse, employer, or Assister). Sign and write today's date. **If the permission is for an Assister, the Assister will sign and write today's date and complete the KP EE number information.**

Permission to share information with the following person:

I give permission to Kaiser Permanente Child Health Plan to give information over the telephone, or to a participating One-e-App agency via disposition, about the status of this application (including whether the 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) to:

Name (of Spouse, Employer, Assister, etc.) Relationship

Signature (of Spouse, Employer, Assister, etc.) Date signed

KP EE #

Address, if an Assister Phone number

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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 *Evidence of Coverage*.

Print Name of Applicant Signature of Applicant

Date signed

By signing this application, I certify that the information in this application is correct and accurate. If I provide any incorrect or incomplete information on this application or in further correspondence concerning this application, my child's coverage may be terminated.

Print Name of Applicant Signature of Applicant