Questions? Call us at CDA Insurance LLC:
1-800-884-2343 or 541-434-9613
Kaiser Application

Tips for completing the application :

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
2. Please complete all sections to the best of your ability. Please pay special attention to The Oregon Standard Health Statement. By including the specific details to questions you answered 'yes" to, the processing of your application will be expedited. Be sure to include:
    - The specific name and date of the diagnosis or condition and correct spelling.
    - The treatment(s} that were done, including the last time you visited the doctor for this condition and medications that were prescribed and medications that are currently being taken.
    - Final result refers to the status of the condition. If it has been treated and your doctor has not requested any follow-ups, please state so. If you are still seeing the doctor, please state so.
    - Complete name, address and phone number of the doctor .

Prior Insurance?

Yes:

Please make a photocopy of your health insurance card(s) or contact your insurance carrier and request a "Certificate of Credible Coverage." Include this with your application.

No:

If your application is approved, when the policy is sent to you, there will be a form that will need to be signed and returned to us stating that you understand there is a 6 month waiting period on pre-existing conditions before you will be covered for conditions that you been diagnosed with or seen a doctor for before the policy is effective.

Payment Option:

The payment options are monthly.

Final check list before mailing your application:

- All sections completed?
- Copy of Insurance Card or Certificate of Credible Coverage
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal-

Send Completed Application to:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

KAISER PERMANENTE®

INDIVIDUALS AND FAMILIES

I Instructions

- Please use **ink** to complete and sign this application.
- Make sure this application is complete and signed. If your application is incomplete, it may delay your effective date. A parent or legal guardian must sign the following on behalf of any child Applicant under age 18: (1) the certification of completion and correctness, (2) the producer authorization (if applicable), and (3) the "Authorization to Obtain or Release Medical Information." Applicants who are age 15 or older must also sign the "Authorization to Obtain or Release Medical Information." Throughout this application, *I* and *you* refer to the Applicant, including when the Applicant is a child for whom a parent or legal guardian is signing. We are unable to process applications without appropriate signatures.
- If you would like help completing this application, please call **1-888-813-3700.**
- When evaluating your application, Kaiser Foundation Health Plan of the Northwest (KFHPNW) will use the following medical information:
  - Information provided on the health questionnaire.
  - Any medical information on file from prior membership, or prior application for membership, with KFHPNW (if applicable).
- To be eligible for Kaiser Permanente Individuals and Families, you must live in our Northwest Oregon service area.
- If you make an intentional misrepresentation of material fact, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny your application for coverage, modify your coverage, or cancel or rescind your coverage contract, and/or take any other legal action available to it by law. Making an intentional misrepresentation of material fact means to intentionally provide incorrect information, or to intentionally omit information, about the health history or status of any person applying for coverage. To rescind coverage means that we will completely cancel the member's coverage back to the first day of such coverage so that such coverage never existed. In such an event, the rescinded member will pay for any services we provided or covered.
- If you are eligible for Medicare, please call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

EXPEDITE YOUR APPLICATION – APPLY ONLINE NOW AT BUYKP.ORG/APPLY.

Mail your completed application to:
Kaiser Permanente for Individuals and Families
P.O. Box 7104, Pasadena, CA 91109

Or send it by secure fax to **866-920-6473**.

II Enrollment Information

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

Applicant	Last name	First name	Middle initial	Previous name(s)		Marital status ☐ Married ☐ Single
Date of birth	Gender ☐M ☐F	Height	Weight	Social Security number	Health record number (if any)	

Residence address		
Residence street address		
City, State, ZIP code		
Home phone number	Work phone number	County
E-mail address (will not be disclosed outside of the company)		

Billing address (complete only if billing should be sent to an address other than listed above)	
Name C/O	Relationship to Applicant
Address/P.O. Box	City, State, ZIP code

For official use only

Date received	❑ New account ❑ Conversion ❑ Add-on	❑ Reapplication ❑ Upgrade	Effective date ❑ Approved	❑ Denied

II Enrollment Information *(continued)*

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

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

*A *domestic partner* is a person legally recognized as your domestic partner in a valid *Certificate of Registered Domestic Partnership* issued by the state of Oregon.

III Plan Selection

Please check all boxes that apply.

Medical:

Choose one Kaiser Permanente Individuals and Families medical plan.

Copayment plans	Deductible plans		Deductible HSA plans
☐ KP 0/20/Rx	**Gold plans** ☐ KP 500/25/Rx ☐ KP 1000/25/Rx	**Bronze plans** ☐ KP 1500/35 ☐ KP 2500/35 ☐ KP 3500/35 ☐ KP 5000/35 ☐ KP 7500/35	☐ KP 1500/20%/HSA/Rx ☐ KP 2600/20%/HSA
	Silver plans ☐ KP 1500/30/Rx ☐ KP 2500/30/Rx ☐ KP 3500/30/Rx ☐ KP 5000/30/Rx ☐ KP 7500/30/Rx	**Child-only plans** ☐ KP 2500/25/Rx ☐ KP 5000/25/Rx	

Dental:

Optional dental plans:
- ☐ Plan 1
- ☐ Plan 2
- ☐ Plan 3

Please note: To enroll in the optional dental plan, you must also be enrolled in an Individuals and Families medical plan.

Additional information about these plans is available upon request.

Note: Your plan options may be limited based on review of your application and medical history.

☐ **I am adding a new person to a current Individuals and Families account with family coverage. If accepted, your family member will be added to your current plan.**
Health record number of your current account: ______________________________

Please allow a minimum of 10 days for the processing of the completed application. Effective date of coverage cannot be more than **60 days** from the date the application is signed.

If approved, I would like to be enrolled with an effective date of:

- ☐ **15th of the current month (Your application must be received by the 8th of the current month.)**
- ☐ **1st of the next month (Your application must be received by the 23rd of the current month.)**
- ☐ **15th of the next month (Your application must be received by the 8th of the next month.)**
- ☐ **1st of the month after the next (Your application must be received by the 23rd of the next month.)**

Note: Premiums for enrollments beginning on the 15th of the month will be prorated for that month only, after which the standard billing cycle (1st of the month) will apply.

IV 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 Applicants age 19 and older for pre-existing conditions during the six months following the 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 **1-800-813-2000** or **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. **Copayment and/or coinsurance**

   ____

7. **Coverage does or did include:**

   ☐ Maternity

   ☐ Hospital only

   ☐ Prescription drug

   ☐ Waiting periods for organ transplants

   ☐ None of the above

8. **Name of Applicant covered by current or prior insurer**

   ____

   ____

9. **Are you currently on or did you recently exhaust, terminate, or decline 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 ☐ Yes ☐ No

    Medicaid ☐ Yes ☐ No

    If you answered Yes to Medicare, do not continue. Call **1-866-523-6056** (TTY 1-800-735-2900), 8:30 a.m. to 4:30 p.m., Monday through Friday, for a Senior Advantage application.

V 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 on page 6 (No. 55) to any questions answered Yes.

If you are unsure whether to answer Yes or No, or if you need help completing this application, please call **1-888-813-3700.**

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

V Questionnaire *(continued)*

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

(continues on page 6)

V Questionnaire *(continued)*

Oregon Standard Health Statement
(Standard form per ORS 743.766)

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

Question Number	Start to end dates	Condition	Treatment, including medications	Final result **Ongoing** or **Resolved** Please check	Attending physician/health care provider or hospital (name/address/telephone)
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	
				☐ Ongoing ☐ Resolved	

Attach additional pages if necessary. ☐ I have attached ________ page(s).

Do you have Medicare or Medicaid coverage? ☐ Yes ☐ No

Name, address, and telephone number of medical provider(s) with the most recent or current health record/history:

VI 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 Kaiser Foundation Health Plan of the Northwest (KFHPNW) to enroll in its health plan.

I understand that if I make an intentional misrepresentation of material fact, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny my application for coverage, modify my coverage, or cancel or rescind my coverage contract, and/or take any other legal action available to it by law. I understand that making an intentional misrepresentation of material fact means to intentionally provide incorrect information, or to intentionally omit information, about the health history or status of any person applying for coverage, and KFHPNW relies upon such misrepresentations when deciding to accept an applicant for coverage. I must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. I understand that 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.

In the event KFHPNW decides to rescind your coverage, we will send you a written notice at least 30 days before we actually rescind, explaining the basis for our decision and how you can appeal it. Once coverage is rescinded, you will be required to pay for any Services we may have covered, but you would also be entitled to a refund of any Premiums paid. This means that Premium refunded would be reduced by any amounts you owe for any covered Services you received.

I understand and agree that no coverage shall be in force until approved by KFHPNW. If approved, coverage will be in force as of the effective date determined by KFHPNW. KFHPNW 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 | Today's date

Producer authorization

(if you are working with a health insurance producer)

I (the Applicant) authorize the insurance producer listed below to share enrollment, disenrollment, and summary plan information specific to this application with KFHPNW.

I understand that the insurance producer of record may receive monetary and/or nonmonetary payments from KFHPNW in connection with the purchase of this health plan coverage.

X ______________________________

Applicant | Today's date

I (the producer) have not made any representations to the Applicant about any provisions, benefits, conditions, or limitations of the health plan agreement 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.

Dann Loewenthal	90050	800.884.2343		dann@lowinsure.co
Producer's name	Number	Phone		E-mail address
CDA Insurance LLC	90050	541.284.2994		
Agency name	Number	Fax		
2160 W 11th suite D	Eugene		OR	97402
Street address	City		State	ZIP

X ______________________________

Producer's signature | **Today's date**

VI Certification/Authorization *(continued)*

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 family member 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 and its affiliates), its respective agents, employees, designees, or representatives, including my KFHPNW 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, or AIDS [acquired immune deficiency syndrome]. 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 family member on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected (except for any Applicant under the age of 19 who must be accepted under applicable law); 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, or HIV/AIDS-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 KFHPNW 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*.

Signatures (required)

X		
Applicant/Parent or legal guardian	Today's date	Date of birth

X		
Applicant (age 15 or over)	Today's date	Date of birth

Important: Applicants age 18 or over must sign and date above on the appropriate signature line. A parent or legal guardian must sign for an Applicant under the age of 18. In addition, Applicants age 15 and 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.

VII Billing Information

Application must be accompanied by payment information for your initial premium. Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last name

First name MI

Street address Apt./Unit #

City State ZIP

2. Credit/Debit card information: ☐ Credit ☐ Debit

☐ Visa ☐ Discover
☐ MasterCard ☐ American Express

Name as it appears on card

Credit/Debit card number

Expiration date

(This page is intentionally left blank.)