



Kaiser Permanente Application

For Individuals And Families in California

Two Easy Steps to Apply

1. Fill out application

(Complete and return all 24 pages.)

2. Fax your application to: 1.866.439.9993

Or mail it to: KaiserQuotes.com

750 Mendocino Avenue, Suite 4
Santa Rosa, CA 95401

KAISERQuotes
[.com](http://KaiserQuotes.com)

phone: 1.877.752.4737
facsimile: 1.866.439.9993

Deadlines:

- 8th of the Month: Coverage begins on the 15th of the same month.
- 23rd of the Month: Coverage begins on the 1st of the next month.

Note: Underwriting requires one to two weeks to process applications.

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES HEALTH COVERAGE APPLICATION

Note: Please answer all questions and print or type **using ink only**. You should sign this application only if you understand each question and agree to the response provided—even if a broker assists you with the application. **If you have questions about completing this application (in English or another language), please call 1-877-752-4737. We will provide translation services and other language assistance free of charge if you need it. Or, if you are working with a broker, please call him or her for assistance.**

Kaiser Foundation Health Plan, Inc. (KFHP), offers family coverage and rates if everyone selects the same benefit plan. If you want coverage for your family on the same KFHP plan, please complete one application for the family. If one family member wants a different benefit plan, he or she must complete a separate application. If a family member wishes to confidentially complete an application, even if selecting the same benefit plan, he or she may either request additional forms from us or use a photocopy of this application.

Health insurance coverage provided by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc., is offered to individuals only. It does not include coverage for dependents. If you want coverage for yourself, you have the choice of KFHP or KPIC. If additional family members want to apply for coverage provided by KPIC, each will need to fill out a separate application.

I Application for Coverage (financially responsible party)

Last name _____

First name _____

MI _____

Residential address for covered party:

Street address _____

Apt./Unit # _____

City _____

State _____

ZIP _____

() _____ Day Evening

Home phone

() _____ Day Evening

Work phone

E-mail address _____

How do you prefer to be contacted? E-mail U.S. mail

Primary spoken language:

English

Other (please specify) _____

II Account Information

Please check all boxes that apply.

1. Are you adding a family member to an existing Individuals and Families Plan account?

Yes No

2. Are you switching coverage/plan selection from an existing Individuals and Families Plan account?

Yes No

3. Are you applying for a new Individuals and Families Plan account?

Yes No

(continues on page 2)

II Account Information *(continued)***4. Which plan would you like to apply for? (Select only one plan.)****Plans offered by KFHP:¹**

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Copayment 25 | <input type="checkbox"/> Deductible 20/500 |
| <input type="checkbox"/> Copayment 40 | <input type="checkbox"/> Deductible 25/1000 |
| <input type="checkbox"/> Copayment 50 | <input type="checkbox"/> Deductible 30/1500 |
| | <input type="checkbox"/> Deductible 40/2000 |
| | <input type="checkbox"/> Deductible 0/1500 with HSA |
| | <input type="checkbox"/> Deductible 0/2700 with HSA |
| | <input type="checkbox"/> Deductible 30/2700 with HSA |

Plans offered by KPIC:¹

-
- Deductible 40/3000 NM
-
-
- Deductible 40/4000 NM with HSA
-
-
- Deductible 0/5000 WM with HSA
-
-
- Deductible 50/5000 NM

5. Are you applying for the optional dental plan?

- Yes, I would like to enroll in the Kaiser Permanente Insurance Company (KPIC) Group Dental Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.
- No

6. Effective date:

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.

7. Because all applicants applying for an Individuals and Families plan are subject to medical review, there is the possibility that one or more members of a family (or a single applicant) may not qualify for the plan for which they apply.

If you or another family member **does not** qualify, may we complete the enrollment for family members who have been approved?

- Yes No

8. If you or another family member does not qualify for the Individuals and Families plan you selected but does qualify for another Individuals and Families plan or rate, we need your instruction:

I am willing to accept enrollment in a plan with different rates or benefits from the one I originally selected. I will be notified of the plan I qualify for and given the option of canceling.

- Yes No

If you do not qualify for any Individuals and Families plan, you may qualify for a HIPAA plan without medical review. Please review and complete Section IX, "HIPAA Eligibility Questionnaire and Request for Enrollment," on page 23.

Note: All applications must be accompanied by payment information. Please make certain that you have provided the necessary information on page 17 of this application.

¹For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* or *Certificate of Insurance* for a particular plan, please call us at 1-877-752-4737.

III Family Members to Be Covered

(Please fill out only the "Self" parts of this section if you are applying for KPIC coverage or for KFHP individual coverage. Complete this entire section only if you are applying for KFHP family coverage.) If any family members have a different home address than the applicant, please list that address under their names. Attach additional pages if necessary.

Self:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
_____	_____			
Social Security number	Primary spoken language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____			

Spouse/Domestic partner:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
_____	_____			
Social Security number	Home address (if different than applicant's)			
Primary spoken language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____				

Child 1:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
_____	_____			
Social Security number	Home address (if different than applicant's)			Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary spoken language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____				

Child 2:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
_____	_____			
Social Security number	Home address (if different than applicant's)			Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary spoken language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____				

Child 3:

_____	_____	_____	_____	_____
Last name	First name	Previous name (if any)	Date of birth	M/F
_____	_____	_____	_____	
Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)	
_____	_____			
Social Security number	Home address (if different than applicant's)			Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary spoken language: <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____				

(continues on page 4)

III Family Members to Be Covered *(continued)*

For each individual listed on page 3, please give the name of the family member's current or most recent primary care physician, along with his or her address and telephone number. Attach additional pages if necessary.

(Please fill out only the "Self" section if you are applying for KPIC coverage or KFHP individual coverage. Complete this entire section only if you are applying for family coverage on a KFHP plan.)

Self:
 Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Spouse/Domestic partner:
 Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child 1: _____
 Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child 3: _____
 Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

Child 2: _____
 Doctor _____
 Phone _____
 Date last visited _____
 Address _____
 City, State, ZIP _____

For each individual for whom you are applying, please give the name of his or her current or most recent health care coverage provider. Attach additional pages if necessary.

Self _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Spouse/Domestic partner _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child 1 _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child 2 _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured
 Child 3 _____ Current **or** Date ended ____ / ____ / ____ **or** Not insured

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a member of KFHP or insured by KPIC. **Each applicant for a KFHP plan or a KPIC insurance policy must pass medical review regardless of current or previous Kaiser Permanente coverage through KFHP or KPIC.** Omissions or incomplete answers regarding your and, if applicable, your family member's (or members') health history will delay processing of your application. **Either intentional or willful misrepresentation of an applicant's health history can result in rescission of coverage for that applicant (see Section VIII for details).**

This application becomes part of your Kaiser Permanente record. If you need assistance completing this medical questionnaire, call your broker. Kaiser Permanente does not discriminate in its decision-making based on: race; color; national origin; ancestry; religion; sex (including gender, gender identity, or gender-related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth); marital status; sexual orientation; age; or genetic information.

Note: This is a family-level questionnaire. You must answer each question for yourself and for everyone you are applying for. Please answer Yes or No to each question. If you are unsure whether to answer Yes or No, or if you need help completing this application, please call your broker. Each question that you answer Yes and each condition that you check Yes requires an explanation. Please see the chart on page 15 and provide the information requested.

Mark the Yes or No box for each letter subquestion. Every line must be answered Yes or No. When you answer each question, answer not only for yourself but for everyone you are applying for.

	Self	Spouse ¹	Child 1	Child 2	Child 3
(Fill in name.)					
1. Within the last 12 months , were you (or anyone you are applying for) hospitalized (excluding labor and delivery) or treated at an Emergency Department, hospital, outpatient surgery center, or skilled nursing facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the last 12 months , have you (or anyone you are applying for) sought advice or treatment from a medical professional's office?					
a) Physical exam	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Minor illness or injury now resolved and without a recommendation of further treatment; for example, cold, allergic reaction, flu, sore throat, cut requiring stitches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Regular chiropractic visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Prenatal care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Psychological counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Medication management	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) A reason not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last 3 years , have you (or anyone you are applying for) been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹Includes domestic partner

(Medical questionnaire continues on page 6.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
4. Within the last 3 years , have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with your (or his/her) alcohol or substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Within the last 3 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any skin/dermatological disorders?					
a) Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Keloids requiring plastic surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Cosmetic or reconstructive surgeries, revisions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) A skin or dermatological condition not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Within the last 3 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any disorders of the eyes, ears, nose, or throat?					
a) Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Cataracts, cataract surgery for one or both eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Crossed eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Detached retina	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Deviated septum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Sleep apnea, chronic snoring, or unresolved insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Nasal and/or throat polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) A condition of the eyes, ears, nose, or throat not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Have you (or anyone you are applying for) ever used tobacco, including snuff and chewing or other smokeless tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, skip to Question 8. If Yes, answer the following questions:					
a) Currently use or have used in the past If Yes, how many years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) If you (or anyone you are applying for) smoke or smoked cigarettes, pipes, and/or cigars, please indicate quantities:					
Cigarettes: How many packs per day?					
Pipes: How many bowls per day?					
Cigars: How many cigars per day?					

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
8. Within the last 5 years , have you (or anyone you are applying for) taken or used illegal drugs or prescription drugs not prescribed by a medical professional for yourself (or anyone you are applying for)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any brain, neurological, or nervous disorder?					
a) Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Seizures treated with more than 2 medications for control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Seizures under control with 2 or fewer medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Most recent seizure within the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Alzheimer's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) A brain, neurological, or nervous disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any heart or cardiovascular disorders?					
a) Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Heart murmur or mitral valve prolapse, with recommendation for ongoing treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Heart attack or angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Angioplasty or coronary artery bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Tachycardia or other heart arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Other heart disease or valve disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Current medication(s) to control heart disease or cardiovascular symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) A heart or cardiovascular condition not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Medical questionnaire continues on page 8.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

11. **Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any respiratory disorders?**

a) Chronic asthma treated with medications for control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Asthma treated with prednisone therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Asthma treated only with occasional use of inhalers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Asthma history of 3 or more Emergency Department visits or hospital admissions within the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Chronic bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Chronic obstructive pulmonary disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Pulmonary tuberculosis, active or arrested	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) A lung or respiratory disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

12. **Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any muscle or bone disorders?**

a) Back or neck pain or injury currently under treatment or controlled with medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Back or neck pain or injury within the last 12 months fully resolved and no longer under treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Back or neck pain or injury for which further treatment or surgery has been recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Inguinal hernia that has been repaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Inguinal hernia not repaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Umbilical hernia that has been repaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Umbilical hernia not repaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Lupus/SLE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Chronic disabling arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Arthritis requiring daily prescription medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Osteomyelitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Joint replacement surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Orthopedic or arthritic conditions that interfere with daily living	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) A musculoskeletal condition not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
13. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any metabolic or endocrine (hormone) disorders?					
a) AIDS <i>California law prohibits an HIV test from being required or used by health care service plans or health insurance companies as a condition of obtaining coverage.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Diabetes controlled with oral medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Diabetes controlled with insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Diabetes controlled exclusively with diet and exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Gestational diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Other immunological condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) A metabolic or endocrine disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any congenital defects or developmental disorders?					
a) Down's syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Cleft palate or lip	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Club foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Congenital heart defect (specify type)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Prematurity (for children up to 2 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) A neurological or physical abnormality not listed above (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Medical questionnaire continues on page 10.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
15. For men only: <i>Within the last 5 years</i>, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him) that any of you have, any of the following:					
a) Prostate condition requiring treatment, medication, or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Genital herpes with a history of daily treatment or more than 3 outbreaks in the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Genital warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Other sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Impotence or erectile dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Gender identity (role) disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) A male reproductive or genital disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

16. For women only: <i>Within the last 5 years</i>, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or her) that any of you have, any of the following:					
a) Ovarian cyst operated on within the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Ovarian cyst controlled by birth control pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Polycystic ovary syndrome (PCOS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Chronic pelvic pain or pelvic inflammatory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Painful or irregular menstrual cycles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Uterine fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Silicone breast implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Saline breast implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Miscarriage within the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Abnormal Pap test	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Genital herpes requiring daily treatment or more than 3 outbreaks in the last 12 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) Genital warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o) Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p) Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
q) Other sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
r) In vitro fertilization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
s) Heavy periods (menstruation) causing low blood iron	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
t) Gender identity (role) disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
u) A female reproductive or genital disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
17. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any digestive system disorders?					
a) Ulcerative colitis or Crohn's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Gastrointestinal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Gastrointestinal polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Unrepaired cystocele or rectocele	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Gallstones and gallbladder has not been removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Hepatitis A, B, C, or other, currently under treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Hepatitis A, B, C, or other, chronic and ongoing (including carrier status)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Hepatitis A, fully recovered with no symptoms and normal liver function tests	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Other liver condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) A digestive system disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Within the last 5 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any urinary tract disorders?					
a) Chronic kidney failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Nephrotic syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Polycystic kidneys	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Kidney failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Chronic kidney infections (more than 2 per year)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Kidney infection, resolved with no further treatment required	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Kidney removed with remaining kidney functioning without any medical problems and normal kidney function tests	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Kidney removed with a recommendation for further treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Kidney stones, currently	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Kidney stones within the last 24 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Interstitial cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) A kidney or urinary tract disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Within the last 5 years , has a medical professional advised you (or anyone you are applying for) that any of you have any abnormal lab results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please list with patient's (or patients') name(s), name(s) of test(s), result(s), and date(s) on page 15.					

(Medical questionnaire continues on page 12.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

20. **Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any blood or circulatory system disorders?**

a) Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Transient ischemic attacks (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Thalassemia major	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Von Willebrand's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Other blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Blood pressure over 150/90	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Currently taking 3 or more medications for hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Hypertension under control with medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) A blood or circulatory system disorder not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

21. **Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any cancer?**

a) Any cancer with lymph node involvement or metastasis (spread to other tissue)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Cancer of the brain, breast, blood, pancreas, prostate, urinary bladder, or esophagus; or myeloma, Kaposi's sarcoma, or non-Hodgkin's lymphoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Cancer of the cervix, uterus, thyroid, larynx, or oral cavity, with no further treatment recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Cancer of the colon, kidney, liver, lung, ovary, or stomach	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Skin cancer that has not been removed and requires further treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Skin cancer other than melanoma that has been completely removed and no further treatment recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) A cancer not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

22. **Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any condition for which prosthetics, implants, or transplants (including organ transplants) have been recommended?**

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire (continued)

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
23. Within the last 10 years , have you (or anyone you are applying for) been treated for, or has a medical professional advised you (or him/her) that any of you have, any psychological or mental health disorders?					
a) Mild depression/anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Major depression or neurosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Situational stress, anxiety, or depression no longer requiring treatment or medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Eating disorder (anorexia nervosa or bulimia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Suicide attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Psychosis, senile dementia, multiple personalities, bipolar disorder, depressive psychosis, schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Hospitalization for a mental health condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) A psychological or mental health condition not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Are you (or anyone you are applying for) taking any prescription medications?					
If Yes, please list the person's name, the medication(s), the dosage, frequency, name/address/phone number of the prescribing medical professional, and the reason the person is taking this medication on page 15.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you (or anyone you are applying for) drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please indicate how much you (or anyone you are applying for) drink <i>per week</i> :					
a) Beer: How many bottles/cans per week?					
b) Wine: How many glasses per week?					
c) Hard liquor: How many drinks per week?					
On average, a beer=12 oz; a glass of wine=8 oz; and a hard liquor drink=1.5 oz.					
26. Are you (or anyone you are applying for) currently pregnant or an expectant father? Or, do you (or anyone you are applying for) expect to be providing medical insurance coverage for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Do you (or anyone you are applying for) plan to be a surrogate parent (mother or father) within the next year or to engage someone to provide that service within the next year ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Medical questionnaire continues on page 14.)

IV Kaiser Permanente for Individuals and Families Plan Medical Questionnaire *(continued)*

	Self	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

28. For females age 11 and older:					
a) Have you ever menstruated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Are your menstrual periods regular? (If you answered No, please explain on page 15.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Are you still having regular menstrual periods? (If you answered Yes, please indicate the date you started your last normal menstrual period on page 15.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Have you (or anyone you are applying for) been treated for, or advised by a medical professional that you have, a medical or health-related condition which you haven't indicated on this medical questionnaire? If so, please provide the appropriate details on the chart on page 15.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

V Agent, Broker, and Representative Information

FOR APPLICANTS USING AN INSURANCE AGENT/BROKER/REPRESENTATIVE

Agent/Broker/Representative name _____

Yes No Did you receive any assistance from an agent, a broker, or a representative of KFHP or KPIC in submitting this application? *Representative* means any representative of KFHP or KPIC who has provided you with such assistance.

I understand that the broker of record may receive monetary and/or non-monetary payments from Kaiser Foundation Health Plan, Inc., and/or Kaiser Permanente Insurance Company in connection with the purchase of this coverage.

Note: Premiums are the same whether or not you use an agent/broker/representative.

X
Applicant signature (Use ink only.) _____ Today's date _____

TO BE COMPLETED BY YOUR KAISER PERMANENTE-APPOINTED AGENT/BROKER/REPRESENTATIVE AFTER COMPLETION OF THIS APPLICATION

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Yes No

Notice to agent, broker, representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

X
Agent/Broker/Representative signature (Use ink only.) _____ Today's date _____

KQ Insurance Services
Name of agent/broker/representative (please print)

20179
Broker ID #

750 Mendocino Ave Suite 4
Address

Santa Rosa, CA 95401
City State ZIP

1-877-752-4737
Phone Fax

support@kaiserquotes.com
E-mail address

VI 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 Dr.

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

Credit/Debit card security number (Usually this is a three- or four-digit code on the back of the card near the signature line. In some cases, it may be on the front of the card.)

Expiration date

Note: Person listed on the Billing Information must be the applicant or the spouse of the applicant.

(This page is intentionally left blank.)

VII Authorization to 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 KFHP or KPIC product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan, Inc., or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, 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, 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 authorize Kaiser Permanente to disclose to my Kaiser Permanente broker or agent 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 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, AIDS-related information, and psychotherapy notes. Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed. I understand that, under California law, the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This authorization is effective on the date that the Applicant signs the application 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 KFHP Plan or insured by KPIC. 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.

(continues on page 20)

VII Authorization to Release Medical Information *(continued)*

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*.

X
 Applicant/Financially responsible party (signing on behalf of self and all applicants/dependents under the age of 12) _____ Today's date

X
 Applicant's spouse/Domestic partner _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

X
 Applicant/Dependent (age 12 or over) _____ Today's date

Important: required signatures

- All Applicants age 18 and over must sign and date above on the appropriate signature line (applicant/financially responsible party, spouse/domestic partner, dependent).
- All Applicants ages 12–17 must sign and date above on the appropriate signature line. (Minors have the right to control the release of certain types of medical history and records. We require that such minors sign in addition to their parents or legal guardians).

Signature by parent or legal guardian represents authorization for himself/herself as well as authorization for minor children.

Use ink only.

VIII Conditions of Acceptance/Arbitration Agreement

You must fully answer each question in this application even though you may already be a KFHP member or a KPIC insured.

If we decide to accept you for KFHP membership or issue you a KPIC policy, our decision will be based primarily on health information you provide in your application and during the enrollment process. If you have or previously had coverage with KFHP or with KPIC, we will review your prior health history with Kaiser Permanente before making our decision. We may review your use of health care services for up to a year following your KFHP or KPIC enrollment to confirm that your actual health status at the time you were accepted for enrollment qualified you for KFHP or KPIC enrollment.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or any other family member applying for coverage under this application, take the time to make sure the information is accurate before submitting it to us. By signing this application, you represent that all responses are true, complete, and accurate to the best of your knowledge, and that if KFHP or KPIC accepts your application for coverage and/or the application of any of your dependents, the application will become part of the plan contract between you and any other applicant(s) and KFHP or KPIC.

Our decision to accept you (or any other applicant on this application) for coverage will be made only after we have thoroughly reviewed the medical history information pertaining to you and any other applicants disclosed in Section IV of this application. Our review will include our reasonable efforts to verify the accuracy and completeness of the information disclosed in Section IV. We are under a duty to complete this process of review and verification of applicant health history information (medical review).

If we determine that you or someone on your behalf either intentionally or willfully gave us incomplete or incorrect material information about the current or past health of any person applying for coverage on this application (or if such intentional or willful misrepresentation of health history was made at any time during the enrollment process), and our decision to accept the enrollment was based on this misinformation, we may rescind the membership of the person whose health history was so misrepresented. This means that we would completely void KFHP membership or the KPIC insurance policy of the misrepresenting individual as if no coverage had ever existed. If we approve the application for coverage for you or any other applicant on this application without properly completing medical review, we may only rescind coverage if we can support a claim that health history information disclosed in Section IV, or material health information not disclosed, was willfully misrepresented or omitted.

Before making any decision to rescind, we would notify you in writing why we believe we have grounds to rescind your coverage. Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm whether your actual health status at the time you were accepted for coverage qualified you for individual plan coverage. If, after considering your response, we decide to rescind, we will explain the basis for our decision and how you can appeal it.

Please note: If the intentionally or willfully provided incomplete or incorrect material health history information relates only to another person on the application (for example, a family member) and not to you as the subscriber, our rescission would not affect you or any other family member on the application because your (or his/her) health history did not lead to our decision to rescind. Conversely, if the intentionally or willfully provided incomplete or incorrect material health history information relates to you only, any other person applying for coverage on this application would not be affected because his/her health history on the application did not lead to our decision to rescind. If the coverage is lawfully rescinded, the rescinded individual may have to reimburse us for the reasonable value of any services that we provided or that we paid for on your (his/her) behalf, if legally permitted. Please refer to the *Membership Agreement* or *Certificate of Insurance* for more information about rescission of membership in KFHP or KPIC. Within 30 days, we will refund all applicable premiums except that we may subtract any amounts you owe us.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf.

(continues on page 22)

VIII Conditions of Acceptance/Arbitration Agreement *(continued)*

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, 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 *Membership Agreement* and in the *Certificate of Insurance*.

I am applying for coverage provided by KFHP or KPIC.

X
Applicant/Financially responsible party _____ Today's date

(Complete the following signatures only if applying for dependent coverage on a health plan from Kaiser Foundation Health Plan, Inc.)

X
Applicant's spouse/Domestic partner _____ Today's date

X
Applicant/Dependent (age 18 or over) _____ Today's date

X
Applicant/Dependent (age 18 or over) _____ Today's date

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (applicant/financially responsible party, spouse/domestic partner, dependent). Parent or legal guardian must sign for dependents under the age of 18.

Use ink only.

For office use only:

Receive date: _____

Accept Reject Rate Alternate

Process date: _____

Effective date: _____

MRN/HRN listed in Section III, page 3

Purch-EU/Grp-Sbgrp: _____

IX HIPAA Eligibility Questionnaire and Request for Enrollment

You may be eligible for Kaiser Permanente individual coverage without medical review. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a law that guarantees individuals health coverage without medical review if they meet the five requirements listed in the questionnaire below. Please complete the questionnaire and return it with the rest of the application so that your eligibility for individual coverage under HIPAA can be determined.

This way, if you do not pass medical review for KFHP Individuals and Families Plan coverage or KPIC insurance coverage but meet all of the following five requirements, you are guaranteed coverage in the Kaiser Permanente HIPAA plan that has benefits most like the plan for which you applied. If you are eligible, then this document is your offer of guaranteed enrollment in the applicable Kaiser Permanente HIPAA plan.

Note: We will enroll you in the applicable Kaiser Permanente HIPAA plan only if you meet HIPAA eligibility requirements and only if your KFHP or KPIC application is declined. If you qualify for HIPAA coverage and applied for and qualify for KFHP coverage, we will enroll you in the KFHP plan. If you qualify for HIPAA coverage and applied and qualify for KPIC coverage, we will enroll you in the KPIC plan. For information about your HIPAA eligibility, plan benefits, and rates, or if you want to request a copy of a *Membership Agreement*, please call 1-877-752-4737.

Questionnaire

Please read the HIPAA requirements below to determine whether all five are true statements for all family members applying for coverage. Then read the declarations on page 24 and check the appropriate response(s) for yourself (and any other family members). Your response(s) on page 24 will instruct Kaiser Permanente whether you or other family members wish to enroll in a HIPAA plan in the event you (or a family member) do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time.
Creditable coverage means continuous health coverage during the qualifying 18-month period immediately preceding this application for enrollment. If there have been multiple coverages during that qualifying period and/or a combination of individual and group coverage, a) there can be a break of no more than 63 days between coverages, and b) the final coverage must have been group coverage. For more information about the types of health coverage that may qualify for creditable coverage, please refer to your *Membership Agreement*, or call us at the information number listed above.
2. My most recent health coverage was through a group health plan, a governmental plan, or a church plan.
3. If I was eligible for continuation of coverage under federal (COBRA) or state (Cal-COBRA) laws, I enrolled in any available continuation coverage and paid all applicable premiums for the entire period for which I was eligible.
4. I do not currently have other health coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare.
5. My most recent coverage was not terminated for fraud or failure to pay premiums.

(continues on page 24)

IX HIPAA Eligibility Questionnaire and Request for Enrollment *(continued)*

Read the declarations below regarding the five statements listed on page 23. Then indicate which declaration is true for yourself and which declaration is true for each member of your family applying for coverage. **Check only one box for each family member applying.**

Print name(s). Use ink only.	All five statements are true. Enroll me in HIPAA if I do not qualify for a KFHP Individuals and Families plan or KPIC Individual plan.	All five statements are true. However, if I do not qualify for a KFHP Individuals and Families plan or a KPIC Individual plan, I do not want to be enrolled in HIPAA.	One or more of the five statements is false. I do not qualify for HIPAA.
_____ Applicant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Applicant's spouse/Domestic partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Applicant/Dependent (age 18 or over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Applicant/Dependent (age 18 or over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Applicant/Dependent (age 18 or over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected a box in the first column, indicating that you (or a family member) want to be considered for HIPAA coverage, please attach certificate(s) of creditable coverage or other proof of creditable coverage. Enrollment in HIPAA for yourself or a family member may be delayed if proof of creditable coverage is not provided. Upon verification of this document, you (and/or family member[s]) will be enrolled for membership in HIPAA.

X

Applicant (Use ink only.)	Today's date
Applicant's spouse/Domestic partner	Today's date
Applicant/Dependent (age 18 or over)	Today's date
Applicant/Dependent (age 18 or over)	Today's date
Applicant/Dependent (age 18 or over)	Today's date

Student Certification — for Kaiser Permanente Individual Plans (DPA)

Requirements for dependent student coverage:

- Must be enrolled in an accredited institution.
- Must be a full-time student.
- Must be dependent upon subscriber for support.
- Must be unmarried.
- Must be under 23 years of age.

I certify that the dependent shown meets all of the requirements for coverage on my account as a full-time student. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

Student Dependent's name Medical Record Number

Subscriber's Name Medical Record Number

School Name Student ID Number

Subscriber's signature Date

School Address

City, State, ZIP**Fax this form to 1-866-439-9993.**

NOTE: This form is only required if you are including child(ren) ages 19-22 on your family plan.

Certificacion de Estudiante**Español**

Requisitos para la cobertura de dependientes que son estudiantes:

- Debe estar inscrito en una escuela acreditada.
- Tiene que ser un estudiante de tiempo completo.
- Debe ser dependiente del suscriptor para su apoyo economico.
- Debe ser soltero.
- Debe de tener menos de 23 anos.

Certifico que dicho dependiente cumple con todos los requisitos para la cobertura en mi cuenta como estudiante de tiempo completo. Entiendo que la cobertura del Plan de Salud para dicho dependiente terminara el primer dia del mes posterior a la fecha en que no se cumplan alguno de estos requisitos.

Nombre del dependiente Numero de Expediente
Medico del dependiente

Nombre del suscriptor Numero de identificacion
del comprador

Nombre de la escuela Numero de identificacion

Firma del suscriptor Fecha

Direccion de la escuela

Ciudad, estado, codigo postal**Mande por fax a 1-866-439-9993.**

NOTE: Solo necesitamos esta forma si está incluyendo niño(s) de 19-22 en su plan para la familia.