



Small Group Employee Enrollment and Change Form with Medical Review

Check One In Each Category:

- Enrollment Form Change Form
HMO
Multi-Choice with HSA Option Self only Family
Out-of-Area PPO with HSA Option Self only Family
Deductible Plan with HSA Option Self only Family

- Check Box: Annual Enrollment, Non-Annual Enrollment, COBRA Enrollment, Conversion, Add Dependent(s), Termination of Subscriber, Drop Dependents, Change of Address, Change Primary Care Provider, Name Change, Waive Coverage
Fill Out Sections: A, B, C, D; A, B, C, D; A, B, D, E; A, B, D, E; A, B, C, D, E; A, D, E; A, B, D, E; A, E; A, B, D, E; A, D, E; A, D, E

To be Completed by Employer:
Effective Date
Group Number
Sub Group
Bill Group

A. Employee Information Note: Please use blue or black ink. Language preference:

Employee information form with fields for Last Name, First Name, MI, Gender, Marital Status, Employee Address, Date of Birth, Social Security Number, City, State, Zip Code, Home Phone, Job Title, Company Name, Date of Employment, Hours Worked, Employment Status, and various checkboxes for contractor status, CCO, and ethnicity.

B. Coverage Status Self Only Self + Spouse Self + Spouse + Child(ren) Self + Child (ren)

Spouse information form with fields for Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Physician ID #, and existing patient checkbox.

Child 1 information form with fields for Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Physician ID #, College Student?, School, and Disabled? checkboxes.

Child 2 information form with fields for Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Physician ID #, College Student?, School, and Disabled? checkboxes.

Child 3 information form with fields for Last Name, First Name, MI, Date of Birth, Social Security Number, Gender, Physician ID #, College Student?, School, and Disabled? checkboxes.





## Dependent Eligibility Guidelines

- To be a family dependent a person must be:
  - The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.
  - Any unmarried, dependent child of the subscriber or the subscriber's spouse, or an unmarried, dependent child who is claimed on the subscriber's federal tax return and is under the group's age limit for dependent status.  
If the dependent child has a different last name than the subscriber, please complete a Dependent Child Verification Form and attach it to this application.
- Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Evidence of Coverage*.
- Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.
- If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Customer Service at (404) 261-2590 before signing this application.

## Personal Information

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy. I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Health Plan of Georgia, Inc., 3495 Piedmont Road, Atlanta, Georgia, 30305.

## NOTICES:

- I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the rescission of my coverage, as well as the coverage of my spouse and covered dependents (if any), without liability to Health Plan and/or KPIC, as applicable, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.
- You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; 3495 Piedmont Road NE; Building 9; Atlanta, GA 30305.
- This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at [kp.org](http://kp.org). Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Customer Service at (404)261-2590.
- HMO plans and the Kaiser Permanente Select Provider benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company.

**IMPORTANT:** Please read the conditions above, and sign and date below. All applications MUST be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

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Signature of Primary Applicant

Date

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E-mail Address (optional)