KPS health plans

ENROLLMENT APPLICATION

CHECK ☑ APPLICABLE BOXES

NEW ENROLLMENT
- ☐ New Group
- ☐ New Employee
- ☐ Open Enrollment
- ☐ Reemployment
- ☐ Plan Choice

CHANGE IN ENROLLMENT
- ☐ Address
- ☐ Newborn
- ☐ Name
- ☐ Death
- ☐ Marriage
- ☐ Adoption (Complete Date of Placement
- ☐ Divorce
- ☐ Other (Explain)

	MONTH	DAY	YEAR
DATE OF CHANGE			
DATE OF PLACEMENT			

Please answer all questions completely and accurately. Include signature of the Subscriber. Incomplete applications or applications submitted without signatures will be returned.

A waiting period may apply for pre-existing conditions, unless you had health insurance prior to enrolling in this KPS plan and the break in coverage does not exceed three (3) months. **Please provide us with a certificate of creditable coverage from your prior plan to have this waiting period waived or shortened** (all health plans are required to provide these Certificates to member(s)). Other proof of prior coverage may be pay stubs, Explanation of Benefits forms, benefit termination from Medicare and Medicaid or verification by a doctor or provider of your prior coverage.

SUBSCRIBER - LAST NAME	FIRST	M.I.	HOME PHONE	WORK PHONE
HOME (MAILING) ADDRESS - STREET & NUMBER	APT. NO.	CITY	STATE	ZIP
EMPLOYER NAME/GROUP NAME			DATE OF EMPLOYMENT	CLASSIFICATION
(EMPLOYER USE) INTENDED EFFECTIVE DATE		**(EMPLOYER USE) GROUP NO.**		**KPS USE**

SUBSCRIBER: List family members to be covered by this plan. Dependent children listed below must meet criteria as stated in the KPS definition of "child." Fill out "Relationship" (i.e., son, daughter). If making enrollment changes, list everyone you want coverage for at this time.

☐ **Check here if you or your dependents have had health insurance coverage in the previous 3 months.**

ADD	DROP	RELATIONSHIP TO SUBSCRIBER	LAST NAME	FIRST	M.I.	DATE OF BIRTH MO	DAY	YR	SEX M	F	KPS ID or SOCIAL SECURITY #	**Previous/Current Health Insurance Plan:** *Acceptable documentation of prior health insurance coverage must be provided to KPS for pre-existing credit to be given.* Please complete the information below. **Plan Name**	**End Date**	**Your Plan ID Number**	**Plan Phone Number**
☐	☐	**SUBSCRIBER**													
☐	☐	**SPOUSE**													
☐	☐														
☐	☐														
☐	☐														

List address of each child listed above if different from subscriber. List name and address of custodial parent of child(ren) to be covered, if applicable. This information is necessary to facilitate the processing of claims submitted on behalf of a dependent child not living with the subscriber.

1. CHILD'S NAME	MAILING ADDRESS	CITY	STATE	ZIP
2. CHILD'S NAME	MAILING ADDRESS	CITY	STATE	ZIP
NAME (CUSTODIAL PARENT)	MAILING ADDRESS	CITY	STATE	ZIP

I hereby grant permission for KPS Health Plans to release and receive any and all medical records, as permitted by law, for purposes of treatment, payment and healthcare operations for anyone making application, enrolled hereunder, or added hereafter. This permission shall become effective immediately and shall remain in effect as long as necessary to enable KPS Health Plans to process the application and claims. I also agree that my employer/group may deduct from my pay the amount, if any, for coverage selected.

I apply for enrollment with KPS for myself and the listed dependents and certify that (a) to the best of my knowledge, we are eligible for the coverage requested; (b) I have reviewed the product information and understand the EXCLUSIONS, LIMITATIONS, and WAITING PERIODS stated therein; and (c) all information on this form is true, correct, and complete. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGNATURE	DATE SIGNED

ENROLLMENT APPLICATION

DEFINITION OF CREDITABLE COVERAGE:
Creditable Coverage is prior health care coverage that is taken into account to determine the allowable length of pre-existing condition exclusion periods. Most health coverage is creditable coverage, including coverage under the following:

- A group health plan
- A health insurance policy
- Part A or Part B of Medicare
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- A State health benefits risk pool
- TRICARE (the health care program for military dependents and retirees)
- Federal Employees Health Benefits Plan
- A public health plan
- State Children's Health Insurance Program
- A health plan under the Peace Corps Act

DEFINITION OF PRE-EXISTING CONDITION EXCLUSION:
Pre-existing condition exclusion limits or denies benefits for a medical condition that existed before the date that coverage began. A "medical condition" is any physical or mental condition resulting from an illness, injury, or congenital malformation---for which medical advice was given, for which a health care provider recommended or provided treatment, within:

- Six months prior to date of enrollment on the plan (Small Group plans)
- Three months prior to date of enrollment on the plan (Large Group and Association plans)

In the case of newborn or adopted children who have a congenital malformation, this Pre-existing condition exclusion does not apply.

Note: If you were required to complete an employer imposed probationary period, the pre-existing condition waiting period begins on the first day of your probationary period.

DEFINITION OF CHILD(REN):

- An unmarried natural child(ren), adopted child(ren), stepchild(ren) or other legally designated ward under the Limiting Age who is a dependent of the Subscriber or the Subscriber's Spouse;
- An unmarried child(ren) under the Limiting Age who is legally entitled to receive medical coverage as a result of a court order binding either the Subscriber or the Subscriber's Spouse, regardless of whether or not the Subscriber's Spouse has legal custody of the child(ren);
- An unmarried child(ren) who has reached the Limiting Age, or is older than the Limiting Age, is incapable of self-sustaining employment due to developmental disability or physical handicap, and is dependent upon the Subscriber or the Subscriber's Spouse for total or partial support and maintenance.