KPS health plans

PO Box 339
400 Warren Avenue
Bremerton, WA 98337

APPLICATION FOR INDIVIDUAL/FAMILY PLAN COVERAGE

KPS is a health care service contractor licensed and marketing in all of Washington State

Please review all accompanying material before completing this application. All answers must be complete and accurate or it will be returned which may cause a delay in coverage. Please PRINT, DATE and SIGN in ink. It must be signed by the applicant and legal spouse (if applying) or legal guardian if applicant is under age 18. To apply, you must be a resident of Washington State and not eligible for Medicare.

Section 1: Type of Application (Check all that apply)

☐ New Enrollment Application

☐ Plan Change (from one KPS Individual/Family plan to another): Subscriber ID # ____________
(Completion of the Washington State Standard Health Questionnaire(s) may be required.)

☐ Adding Dependent Child: Subscriber ID # ____________

- ☐ Newborn: Date of birth ____/____/____
- ☐ Adoption: Date of adoption or placement for adoption ____/____/____
- ☐ Court Order: Date of order ____/____/____ (Please provide documentation of court order effective date.)

☐ Adding Spouse: Subscriber ID # ____________

☐ Transferring from KPS Group Plan: Group # ____________ Subscriber ID # ____________
(If approved, a request to cancel your group coverage will be required.)

Section 2: Applicant Information

Please complete the following in full for subscriber, spouse and eligible children for whom you are requesting coverage. Applicant and legal spouse must not be eligible for Medicare; children must be under age 25, unmarried, and eligible as your dependents.

	NAME (LAST, FIRST, MIDDLE INITIAL) Add separate sheet if additional space is needed.	SOCIAL SECURITY #	SEX		BIRTH DATE		
			M	F	MONTH	DAY	YEAR
Applicant							
Spouse							
Child							
Child							
Child							

Resident Street Address (required - a PO Box will not be accepted)	City	County	State	Zip
Mailing address (if different)	City	County	State	Zip

Occupation	Employer	Home Telephone ( )	Work Telephone ( )

Section 3: Plan Choice

☐ Sound Harbor Elite	☐ Sound Harbor Essential Five - $2,500 Deductible*
☐ Essential Plus*	☐ Sound Harbor Essential Five - $5,000 Deductible*
The Healthy Investor™ - Health Savings Account Plans	
☐ $1,750 Individual/$3,500 Family Deductible*	☐ $1,750 Individual/$3,500 Family Deductible RX*
☐ $2,600 Individual/$5,150 Family Deductible*	☐ $2,600 Individual/$5,150 Family Deductible RX*

☐ **Washington Dental Service** (9706 Fourth Avenue NE, Seattle, WA 98115-2157) dental coverage for myself and all eligible dependents. Please see sales brochure for information on this option.

*This plan provides catastrophic coverage. By enrolling in a catastrophic plan, you may lose portability rights should you decide at a later date to switch to another individual/family health plan. In addition you may be asked to complete another Standard Health Questionnaire for Washington State.

Section 4: Exemptions for the Standard Health Questionnaire

A separate Standard Health Questionnaire is required for each family member applying unless one of the exemptions listed below applies. Please refer to the Standard Health Questionnaire for Washington State for complete instructions and a full explanation of the exceptions.

Name of person(s) not required to complete the Standard Health Questionnaire for Washington State:

____

Reason for exception (check one):

- ☐ **Addition of:** newborn, a newly adopted child, or a child placed for adoption, to my existing KPS Individual/Family Plan within 60 days of birth, adoption, or date of placement for adoption. *For an adopted child, please include documentation indicating the date of adoption or placement for adoption.*
- ☐ **COBRA Exhaustion:** I have used up all the available time on COBRA continuation coverage. I am applying within 90 days from the date COBRA coverage ended. *Please include a copy of your Certificate of Creditable Coverage or other proof verifying that you have exhausted your COBRA benefits.*
- ☐ **COBRA Termination:** while on COBRA coverage, my former employer has gone out of business. I am applying within 90 days from the date coverage ended. *Please include a letter of verification from your employer or carrier.*
- ☐ **Relocation:** I have relocated within Washington State, and the insurance carrier I had does not offer coverage where I live now. I am applying within 90 days of moving. *Please include a copy of a utility bill in your name from the prior address and a letter of verification from your prior carrier.*
- ☐ **Provider Cancellation:** my health care provider has left my current individual/family plan's network within the last 90 days of this application. I have had some service from the provider during the 12 months prior to the provider leaving my current plan's network and the provider is participating in a KPS provider network. *Please include a letter of verification from the provider or carrier.*
- ☐ **Employer Not Required to Offer COBRA:** my employer normally employs fewer than 20 employees, or is a church plan, and is not required to offer COBRA coverage. I have had at least 24 months of continuous group coverage immediately prior to disenrollment, am applying for KPS Individual/Family Plan coverage no more than 90 days prior to disenrollment, and my effective date of coverage will be either the date of disenrollment or within 90 days thereafter. *Please include a letter of verification from your employer.*
- ☐ **Basic Health Plan of Washington (BHP):** I have had at least 24 months of continuous BHP coverage from a BHP participating carrier. I am applying within 90 days of my BHP coverage termination. *Please provide verification of your BHP coverage.*

Section 5: Smoker/Non-Smoker Certification Statement

I have used tobacco products during the prior 12 months.	Yes	☐	No	☐
My Spouse has used tobacco products during the prior 12 months.	Yes	☐	No	☐

Applicant Signature ______________ Date ______________

Spouse Signature (if applying) ______________ Date ______________

Section 6: Prior or Current Coverage

KPS Individual/Family Plans contain a nine (9) month pre-existing condition waiting period. You will receive credit for prior Creditable Coverage (coverage that provided equal or greater overall benefit coverage than the KPS Individual/Family Plan you have chosen, other than a catastrophic health insurance plan) if it was continuous and terminated no more than three (3) months immediately preceding your effective date of enrollment in a KPS Individual/Family Plan. No credit will be given if there was more than a three (3) month break in coverage between your prior plan and your effective date of enrollment in a KPS Individual/Family Plan.

Please complete the following information and attach a copy of your Certificate of Creditable Coverage from your prior or current carrier. If you do not have a Certificate of Creditable Coverage, you may provide other appropriate documentation that includes the beginning and ending dates of your prior coverage (e.g., pay stubs, Explanation of Benefits forms, benefit termination from Medicare and Medicaid, or verification by a doctor or provider of your prior coverage). Most health care 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, a health plan under the Peace Corps Act, State Children's Health Insurance Program

- Carrier Name (Insurance Company): ______________________________
- Name of subscriber (contract holder) and ID#: ______________________________
- Names of enrollees on current/prior coverage: ______________________________
- Effective date of coverage: ______________ Termination and/or paid through date ______________
- Deductible amount: $ __________ per individual per year Deductible amount: $__________ per family per year
- Was your most recent coverage with a group plan? Yes ☐ No ☐
- What type of benefits did it cover? (check all that apply)
  ☐ Maternity ☐ Hospital Only ☐ Accident Only ☐ Prescription Drug

If your prior coverage was with KPS Health Plans group coverage, then it is not necessary to include a Certificate of Creditable Coverage.

Section 7: Conditions of Enrollment

PLEASE READ CAREFULLY

- I am applying for enrollment with KPS Health Plans for myself and the family members listed.
- I certify that all statements and answers on this application and the health questionnaire are complete and true.
- I understand 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.
- I further understand that I must notify KPS Health Plans immediately of any change in my/our health status that may occur between now and the effective date that I have requested.
- I understand that this application is not an offer of coverage from KPS Health Plans and that submission of this application and receipt of my money (check, or money order) does not constitute enrollment in the plan or guarantee I will receive coverage.
- I understand that the benefits of this contract are subject to waiting periods as follows:

WAITING PERIODS:

(a) **Organ Transplants:** Benefits for organ transplants are not provided during the first 12 months that an enrollee is covered under this contract.

Credit to the waiting period *for organ transplants will be given only when transferring directly (application for transfer must be made within 30 days with no break in coverage) from a contract provided by KPS Health Plans (other than a catastrophic plan). Credit to the waiting period is limited by the length of time continuously covered by the prior plan.*

(b) **Pre-existing Conditions:** During the first nine (9) months that an enrollee is covered under this contract, benefits are not provided for treatment of any pre-existing condition that was present within six (6) months before the effective date of coverage. A pre-existing condition is any medical condition, illness or injury for which you received medical advice; or for which your Provider recommended or provided treatment including prescription medications; or for which a prudent layperson would have sought advice or treatment, within the six (6) month period immediately preceding your effective date in this Individual/Family Plan. Genetic information shall not be treated as a pre-existing condition unless there has been a diagnosis of the condition related to the specific genetic information.

NOTE: Under Washington State regulations, the waiting period for pre-existing conditions cannot be applied to the following:

- Prenatal care or newborns, including an adopted child if the child becomes covered within 60 days of birth, date of adoption or placement for adoption
- Formulas necessary for the treatment of phenylketonuria (PKU)
- Eligible individuals as defined by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

  Definition of "eligible individual": In order to be considered an eligible individual for coverage on a *guaranteed-issue* basis, you must meet **all** of the following criteria:
  - ✓ You must have at least 18 months of creditable coverage without a three (3) month break in coverage;
  - ✓ Your most recent coverage must have been under a group health plan;
  - ✓ You cannot currently be eligible for Medicare or Medicaid or be covered under any other health insurance;
  - ✓ Your most recent coverage cannot have been terminated because of fraud or non-payment of premium; and
  - ✓ You have both elected and exhausted any continuation coverage available under COBRA or a similar state program.

Credit to the waiting period for pre-existing conditions will be given if the person is continuously enrolled (a gap of no more than three (3) months) in a plan with equivalent or greater benefit coverage (other than a catastrophic plan) within the nine (9) month period immediately preceding the initial date of eligibility.

- **I understand that I must remain a permanent resident of Washington State and cannot be eligible for Medicare coverage to have coverage under a KPS Individual/Family Plan.**
- I understand, and agree, that I am applying for individual/family health coverage and that it is not sold or issued for use as an employer-sponsored health plan.

PERMISSION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I hereby grant permission for KPS Health Plans to release and receive any and all medical records, permitted by law, for purposes of treatment, payment and health care 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.

A PHOTOCOPY OF THIS PERMISSION STATEMENT SHALL BE AS VALID AS THE ORIGINAL

Section 8: Signatures

Before you sign the application, be sure that you read and understand the conditions listed in Section 7.

I, the undersigned, have read and personally completed all of the requested information on this form. (If not, please attach a letter of explanation.) I hereby apply for coverage with KPS Health Plans for myself and listed dependents on this application for coverage under the Individual/Family Plan indicated on this form. I understand I will have the right to examine and return the contract within 15 days of its delivery to me.

____ Date ____________________
Applicant's Signature

____ Date ____________________
Spouse's Signature (if applying)

____ Date ____________________
Parent/Legal Guardian Signature (if applicable) Note: Parent/Legal Guardian must sign for dependent children.

Approved applications **received by the 20th of the month** will be considered for an effective date of the first of the following month unless another future date (within 90 days of the application date) is noted here: ______________________

If coverage is denied, you will be notified by mail and application materials will be included to apply for coverage under the Washington State Health Insurance Pool.

YOU MUST INCLUDE YOUR PAYMENT FOR THE FIRST MONTH'S PREMIUM WITH THIS APPLICATION. Make your check or money order payable to KPS Health Plans. Return the form(s) with payment in the envelope we have provided or to:

KPS Health Plans, P.O. Box 339, Bremerton, Washington 98337-0039

If you wish to have subsequent payments directly transferred from your bank account, complete the AUTHORIZATION AGREEMENT FOR "SURE PAY" form and include it with the above. You will receive a bill until the authorization is processed.

PLEASE REMEMBER TO COMPLETE THE ENCLOSED HEALTH QUESTIONNAIRE

Please tell us how you heard about KPS Health Plans:

____ Newspaper ____ Phone Book ____ Friend ____ Website

____ Direct Mail ____ Agent ____ Radio ____ Other

Section 9: Agent Information

FOR AGENT USE ONLY

AGENT VERIFICATION:

Please complete the following AFTER the applicant has completed the application and health questionnaire.
To the best of my knowledge, the answers on this application and health questionnaire are complete and accurate.

Agent/Agency Name - as licensed with KPS (please print)	Agent Signature			Agent No.
Mailing Address	City	State	Zip	Telephone No.