



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 1-800-501-1472. 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.

You may use this application to apply for Kaiser Permanente for Individuals and Families (KPIF) coverage as an individual or as a family. If you want coverage for your family on the same KPIF plan, please complete one application for the family. If a 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, he or she may either request additional forms from us or use a photocopy of this application.

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

Mail your completed application to:
Kaiser Permanente for Individuals and Families
P.O. Box 7104, Pasadena, CA 91109
Or send it by secure fax to **1-866-920-6471**.

Primary Applicant Information

Last name _____

First name _____ MI _____

Street address _____ Apt./Unit # _____

City _____ State _____ ZIP _____
() Day Evening

Home phone _____
() Day Evening

Work phone _____

Email address _____

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) _____

Primary spoken language:
 English Other (please specify) _____

Mailing address (if different than home address):

Street address _____ Apt./Unit # _____

City _____ State _____ ZIP _____

Parent or legal guardian information
(if application is for a child-only Applicant under age 19)

Last name _____

First name _____

Same address as primary applicant

Street address _____ Apt./Unit # _____

City _____ State _____ ZIP _____
()

Phone number _____

Date of birth _____ Gender _____ Relationship to Applicant _____

(continues on page 2)

I Primary Applicant Information (continued)

According to Colorado state law, a small group employer with 50 or fewer eligible employees may not pay for or reimburse an employee through wage adjustment or a health reimbursement arrangement or otherwise pay for any portion of the premium on the individual policy being applied for if the employer has had a small group health benefit plan providing coverage to any employee in the previous 12 months. To see if individual health coverage is right for you, please answer the following questions. If left blank, your application will not be processed. **(The following questions do not apply to child-only applicants under age 19.)**

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Will an employer of 50 or fewer eligible employees be paying for or reimbursing an employee through wage adjustment, a health reimbursement arrangement, or otherwise for any portion of the premium on the policy being applied for?
<p>If you answered Yes, please continue to the next question. If you answered No, please continue to Account Information.</p>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Did the employer have a small group health benefit plan providing coverage to any employee in the 12 months prior to the date of this application?

If the answer to question 1 is Yes and the answer to question 2 is No, the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous 12 months. The affidavit form to be executed by the employer is attached. If the answer to both questions 1 and 2 is Yes, the Applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

II Account Information

Please check all boxes that apply.

1. Are you adding a family member or dependent to your current KPIF account with family coverage? If accepted, your family member or dependent will be added to your current plan.

Yes No Medical record number and plan name of your current KPIF account _____

If you answered Yes, please provide your medical record number in the space above and skip to question 5.

2. Are you switching coverage/plan selection from a current KPIF account?

Yes No Medical record number and plan name of your current KPIF account _____

If you answered Yes, please provide your medical record number in the space above and skip to question 4.

3. Are you applying for a new KPIF account?

Yes No

4. Which plan would you like to apply for? (Select only one plan.)

<input type="checkbox"/> KP 3000/30/Rx	<input type="checkbox"/> KP 4000/30/Rx	<input type="checkbox"/> KP HSA 2000/20/Rx
<input type="checkbox"/> KP 2000/30/Rx	<input type="checkbox"/> KP 7500/30	<input type="checkbox"/> KP HSA 2500/20/Rx
<input type="checkbox"/> KP 1500/30/Rx	<input type="checkbox"/> KP 5000/30	<input type="checkbox"/> KP HSA 3000/20/Rx

You may not qualify for the plan you request at the standard rate. However, you may qualify for that plan at a higher rate or for a different plan. If so, we will enroll you in the requested plan at the higher rate, or the closest plan for which you qualify. We will notify you of the plan or rate change with your acceptance letter. You will be permitted to cancel your enrollment without financial penalty.

(continues on page 3)

II Account Information *(continued)***5. 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: Effective dates for applicants under the age of 19 may vary.

We will do our best to honor your desired effective date if you are approved. 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. If for some reason there is a delay in processing your application, we may need to select the next available effective date.

III Family Members to Be Covered

Complete this entire section if you are applying for KPIF coverage for yourself and your family members. If any family members have a different home address than the primary Applicant, please list that address under their names. Attach additional pages if necessary.

Spouse:

Last name	First name	Previous name (if any)	Date of birth	M/F
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Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)
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Home address (if different than primary Applicant's)

Child 1:

Last name	First name	Previous name (if any)	Date of birth	M/F
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Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)
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Home address (if different than primary Applicant's)

Child 2:

Last name	First name	Previous name (if any)	Date of birth	M/F
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Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)
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Home address (if different than primary Applicant's)

Child 3:

Last name	First name	Previous name (if any)	Date of birth	M/F
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Height (ft/in)	Weight (lbs)	Marital status	Current or previous Kaiser Permanente medical record number (if any)
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Home address (if different than primary Applicant's)

(continues on page 4)

III Family Members to Be Covered (continued)

Complete the "Primary Applicant" parts of this section if you are applying for KPIF coverage as an individual. If your application is for child-only enrollment, the child's information should be entered in the "Primary Applicant" part of this section. Complete this entire section if you are applying for yourself and your family members.

Please give the name of each family member's current or most recent primary care physician, along with his or her address and telephone number. Please also give the name of each family member's current or most recent health coverage provider.

Note: Failure to provide physician information will significantly delay processing of your application.

Primary Applicant: _____

Doctor: _____

Phone: _____

Date last visited: _____

Address: _____

City, State, ZIP: _____

Health coverage provider: _____ Current

or Date ended ____ / ____ / ____ or Not insured

Spouse: _____

Doctor: _____

Phone: _____

Date last visited: _____

Address: _____

City, State, ZIP: _____

Health coverage provider: _____ Current

or Date ended ____ / ____ / ____ or Not insured

Child 1: _____

Doctor: _____

Phone: _____

Date last visited: _____

Address: _____

City, State, ZIP: _____

Has your child had coverage within the last 63 days?

Yes. Please proceed to page 5.

No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)

Yes. Please provide the information requested below.

No. Please proceed to page 5.

Health coverage provider: _____

Policy ID: _____

Start date of coverage: _____

End date of coverage: _____

Child 2: _____

Doctor: _____

Phone: _____

Date last visited: _____

Address: _____

City, State, ZIP: _____

Has your child had coverage within the last 63 days?

Yes. Please proceed to page 5.

No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)

Yes. Please provide the information requested below.

No. Please proceed to page 5.

Health coverage provider: _____

Policy ID: _____

Start date of coverage: _____

End date of coverage: _____

Child 3: _____

Doctor: _____

Phone: _____

Date last visited: _____

Address: _____

City, State, ZIP: _____

Has your child had coverage within the last 63 days?

Yes. Please proceed to page 5.

No. Please proceed to the next question.

Was your child's most recent coverage an individual child-only plan? (An individual child-only plan is a plan in which a child is on his/her own policy.)

Yes. Please provide the information requested below.

No. Please proceed to page 5.

Health coverage provider: _____

Policy ID: _____

Start date of coverage: _____

End date of coverage: _____

IV Kaiser Permanente for Individuals and Families Medical Questionnaire

Instructions: You must fully answer each question in this application even though you may already be a Kaiser Foundation Health Plan member. **Each Applicant for a KPIF plan must undergo medical review regardless of current or previous Kaiser Permanente coverage.** Omissions or incomplete answers regarding your or, if applicable, your family member's (or members') health history will delay processing of the application. **We may rescind coverage once the Applicant is covered if the Applicant makes an intentional misrepresentation of material fact in the medical questionnaire (see Section IX for details).**

This application becomes part of the Applicant's Kaiser Permanente record. If you need assistance completing this medical questionnaire, you may call us toll free at **1-800-501-1472**, or you may 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.

This is a family-level questionnaire. You must answer each question and subquestion 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 1-800-501-1472. Each question that you answer Yes and each condition that you mark Yes requires an explanation. Please see the chart on pages 14–15 and provide the information requested.

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
1. Hospitalization: <i>Within the last 12 months</i> , 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. Office visits: <i>Within the last 12 months</i> , 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) 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. Pending treatment: <i>Within the last 3 years</i> , 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

(Medical questionnaire continues on page 6.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
4. Substance abuse treatment: <i>Within the last 3 years</i> , have you (or anyone you are applying for) been instructed to attend, attended, or participated in a program that deals with <i>your (or his/her)</i> 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. Skin/Dermatological: <i>Within the last 3 years</i> , have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Eyes/Ears/Nose/Throat: <i>Within the last 3 years</i> , have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Tobacco history: 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
a) If Yes, how many years?					
b) Have you stopped using tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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) If Yes, how many years ago did you quit?					
d) If you 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 Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
8. Illegal drugs: <i>Within the last 5 years</i> , 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. Nervous system: <i>Within the last 5 years</i> , have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Cardiovascular system: <i>Within the last 5 years</i> , have you (or anyone you are applying for) been treated for, or has a medical professional advised 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 Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

11. **Respiratory system: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. **Musculoskeletal system: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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 (Examples of daily living include bathing, dressing, grooming, or walking.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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

V Kaiser Permanente for Individuals and Families Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
13. Metabolic/Endocrine system: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any metabolic or endocrine (hormone) disorders?					
a) AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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. Congenital/Developmental: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised that any of you have, any congenital defects or developmental disorders?					
a) Down 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 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
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 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

(Medical questionnaire continues on page 10.)

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

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

15. **For males only: Within the last 5 years, have you (or any males you are applying for) been treated for, or has a medical professional advised 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 females only: Within the last 5 years, have you (or any females you are applying for) been treated for, or has a medical professional advised 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 Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
17. Digestive system: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Urinary tract: Within the last 5 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Lab results: 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 Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					

20. **Circulatory system: Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. **Cancer: Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. **Prosthetics/Implants/Transplants: Within the last 10 years, have you (or anyone you are applying for) been treated for, or has a medical professional advised 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 Medical Questionnaire (continued)

	Primary Applicant	Spouse	Child 1	Child 2	Child 3
(Fill in name.)					
23. Mental health: <i>Within the last 10 years</i> , have you (or anyone you are applying for) been treated for, or has a medical professional advised 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. Prescriptions: Are you (or anyone you are applying for) taking any prescription medications?					
If <i>Yes</i> , please list the person's name, the medication(s), the dosage, frequency, the reason the person is taking this medication, and the name/address/phone number of the prescribing medical professional on the chart on page 14.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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. Alcohol: 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 <i>Yes</i> , 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. Pregnancy: Are you (or anyone you are applying for) <i>currently</i> pregnant or an expectant father? Or, do you (or anyone you are applying for) <i>expect to be providing</i> 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. Surrogacy: Do you (or anyone you are applying for) plan to be a surrogate parent (mother or father) <i>within the next year</i> or to engage someone to provide that service <i>within the next year</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

(Medical questionnaire continues on page 14.)

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

	Primary Applicant	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 <i>No</i> , 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 <i>Yes</i> , please indicate on page 15 the date you started your last normal menstrual period.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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. **Other: Within the last 5 years**, have you (or anyone you are applying for) been treated for, or advised by a medical professional that any of 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
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Please fill in the charts below if you (or anyone you are applying for) answered *Yes* to question 24. Attach additional pages if necessary.

Applicant's name	Name of prescription medication	Reason for taking medication
Dosage/frequency	Prescription medication start date	Prescription medication end date
Name/address/phone number of prescribing medical professional		

Applicant's name	Name of prescription medication	Reason for taking medication
Dosage/frequency	Prescription medication start date	Prescription medication end date
Name/address/phone number of prescribing medical professional		

Applicant's name	Name of prescription medication	Reason for taking medication
Dosage/frequency	Prescription medication start date	Prescription medication end date
Name/address/phone number of prescribing medical professional		

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

Please fill in the charts below for each question answered Yes or each condition marked Yes in the preceding questionnaire. Attach additional pages if necessary.

Question # and letter	Family member affected	Date of diagnosis	Treatment start date	Treatment end date
Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)				
Name/address/phone number of treating physician				

Question # and letter	Family member affected	Date of diagnosis	Treatment start date	Treatment end date
Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)				
Name/address/phone number of treating physician				

Question # and letter	Family member affected	Date of diagnosis	Treatment start date	Treatment end date
Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)				
Name/address/phone number of treating physician				

Question # and letter	Family member affected	Date of diagnosis	Treatment start date	Treatment end date
Explanation (diagnosis, treatment, current state of condition, lab test results, menstrual period, other)				
Name/address/phone number of treating physician				

V Broker/Agent Authorization

FOR APPLICANTS USING AN INSURANCE BROKER/AGENT

Broker/Agent name Steve Roper / Roper Insurance

Yes No Did you, or anyone you are applying for, receive assistance from a broker/agent in filling out this application?

I understand that the broker of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan in connection with the purchase of this health plan coverage.

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

X

Primary Applicant/Parent or legal guardian (Use ink only.) Today's date

TO BE COMPLETED BY YOUR KAISER PERMANENTE-APPOINTED BROKER/AGENT

Steve Roper / Roper Insurance
Agent name (please print)

442113
Agent ID #

116 Inverness Dr. East #265
Address

Englewood CO 80112
City State ZIP

303 721-1145 303 721-1085
Phone Fax

uw@roperinsurance.com
Email address

VI Billing Information

All applications must be accompanied by a credit/debit card payment for the first month's premium. Please make certain that you have provided the necessary information on this page. 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.

For child-only applications, the credit/debit account provided will not be charged for the first month's premium. Instead, a paper invoice will be sent for which payment must be made within 45 days of the date of the invoice.

All applicants may sign up for electronic funds transfer (EFT) for the monthly premiums going forward. The EFT enrollment form will be included in the approval letter.

Credit/Debit card information: Credit Debit
 Visa Discover MasterCard American Express

 Cardholder's name as it appears on card

 Credit/Debit card number

 Expiration date

 Cardholder's billing address

 Apt./Unit #

 City

 State

 ZIP

(This page is intentionally left blank.)

The primary Applicant and spouse, if applying together, must complete, sign, and date this page for their application to be considered complete. (The following section does not apply to child-only applicants under age 19.)

VII Business Group of One Determination Form

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you or your spouse either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you or your spouse have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that is sufficient to pay for the annual premiums for the Business Group of One's health benefit plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?

Please sign below

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant _____ Date _____

I, _____, attest that the answers to the questions contained in this form are true and correct.

Signature of spouse _____ Date _____ Applicant's or spouse's business _____

If you or your spouse answered Yes to all four questions listed above, please complete and sign the following Business Group of One Disclosure Form.

Please note: For Applicants who qualify as a Business Group of One, Colorado law requires that we either accept all the Applicant's family members or deny all the Applicant's family members. Therefore, if you (or your spouse, if he or she is older) answered Yes to all four questions, your application will be denied if any family member does not pass medical underwriting (except for any Applicant under the age of 19, who must be accepted under applicable law). We will notify each individual who did not pass review under separate cover and specify the reasons why he or she did not pass review. (The following section does not apply to child-only applicants under age 19.)

VIII Business Group of One Disclosure Form

Please read and sign the following disclosure required by Colorado law:

I, _____, meet the definition of a self-employed Business Group of One as attested to on the accompanying *Business Group of One Determination Form*. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group Business Group of One policy are limited to plan design, the carrier's overall cost and utilization trends (*index rate*), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans.

Applicant's name _____ Applicant's signature _____

Applicant's business _____ Date _____

All Applicants or legal representatives of Applicants: Please read the follow information and sign in the space(s) provided below.

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Service representative at 1-800-634-4579 before signing this application.

IX Conditions of Acceptance

You must fully answer each question in this application even though you may already be a Health Plan member. If we decide to accept you or your dependents for KPIF membership (any Applicant under the age of 19 must be accepted under applicable law), our decision would be based primarily on health information you provided in your application and would be dependent on your actual health condition being consistent with the information you provided. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician to clarify your specific condition.

If you are a present or former Health Plan member, we will review your prior health history with Kaiser Permanente before making our decision. We reserve the right to review your use of health services during your first year of membership to confirm consistency with your preenrollment health information.

Be sure to complete the form accurately. If you are unsure about the answer to any question for yourself or a dependent, take the time to make sure the information is accurate before submitting it to us.

Your effective date will be the date that you selected in answer to question 5 in Section II unless your application is not completed and processed in time. In that instance, if you are accepted, we will offer coverage for the next effective date permitted for the type of policy for which you are applying. Please note that if we request additional information to make your application complete and such information is not received within 30 days of our request, then we will consider your application abandoned and we will return your application to you.

We may rescind your coverage or that of your dependents if the Applicant (or person seeking coverage on behalf of the Applicant) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. Making an intentional misrepresentation of material fact includes intentionally providing incomplete or incorrect information about health history or status of any person applying for coverage on this application, and such information was the basis for our decision to accept you or your dependents for coverage. Rescinding coverage means completely voiding the member's contract of coverage as if no coverage had ever existed.

If we decide to rescind coverage, we will send you a written notice at least 30 days before we actually rescind, explaining the basis for our decision and how you can appeal it. Once coverage is rescinded, you will be required to pay for any services we may have covered. But you would also be entitled to a refund of any premiums paid. However, we will reduce your premium refund, if any, by the amount(s) you owe for any covered service(s) you received.

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.

Important note to the Applicant: You or your authorized representative may request a copy of your completed application. For more information, please call **1-800-634-4579**.

Primary Applicant/Parent or legal guardian

- -

Applicant's Social Security number

X

Applicant's signature

Today's Date

Spouse

- -

Spouse's Social Security number

X

Spouse's signature

Today's Date

IX Conditions of Acceptance *(continued)*

Dependent (age 18 and over)

Dependent's printed name

- -

Dependent's Social Security number

X

Dependent's signature

Today's Date

Dependent (age 18 and over)

Dependent's printed name

- -

Dependent's Social Security number

X

Dependent's signature

Today's Date

Dependent (age 18 and over)

Dependent's printed name

- -

Dependent's Social Security number

X

Dependent's signature

Today's Date

Dependent (age 17 and under)

Dependent's printed name

- -

Dependent's Social Security number

Dependent (age 17 and under)

Dependent's printed name

- -

Dependent's Social Security number

Dependent (age 17 and under)

Dependent's printed name

- -

Dependent's Social Security number

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for dependents under the age of 18. **Use ink only.**

X Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

XI 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 me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan product (each, an *Applicant*) to give Kaiser Foundation Health Plan of Colorado, or its affiliates (*Kaiser Permanente*), their respective agents, employees, designees, or representatives, including my Kaiser Permanente agent or broker, **any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, sexually transmitted diseases, HIV (human immunodeficiency virus) status, or AIDS (acquired immune deficiency syndrome) (Medical Information)** of the Applicant. However, Medical Information does not include genetic information or *psychotherapy notes* (as defined by 45 C.F.R. § 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize Kaiser Permanente to disclose to my Kaiser Permanente broker or agent the status of my application for coverage, as well as that of any dependents on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected (except for any Applicant under the age of 19 who must be accepted under applicable law); if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for 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 any Medical Information, HIV/AIDS-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective on the date that the Applicant signs the application and will remain in effect for a period of twenty-four (24) months. 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.

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
Primary Applicant/Parent or legal guardian _____ Today's date
(signing on behalf of self and all dependents under the age of 12)

X
Applicant's spouse _____ 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 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for dependents under the age of 18. In addition, all Applicants age 12 or over must sign and date above on the appropriate signature line. **Use ink only.**

XII Kaiser Foundation Health Plan Arbitration Agreement

Except for: (1) claims filed in Small Claims Court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a) (1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the *Medicare Managed Care Manual*, your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians ("respondent[s]"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Note: Any intentional misrepresentation of your current health status may void your coverage or the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

X
 Primary Applicant/Parent or legal guardian _____ Today's date
 (signing on behalf of self and all dependents under the age of 18)

X
 Applicant's spouse _____ Today's date

X
 Applicant/Dependent (age 18 or over) _____ 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. Parent or legal guardian must sign for dependents under the age of 18. **Use ink only.**

XIII Information about CoverColorado

Colorado residents who do not qualify for Kaiser Permanente for Individuals and Families plans may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. CoverColorado does not impose pre-existing conditions or limitations on coverage. For information about CoverColorado, please contact that agency directly at:

CoverColorado
 425 S. Cherry St., Suite 160
 Glendale, CO 80246
 (303) 863-1960
 covercolorado.org
 covercolorado@covercolorado.org

For office use only:	PH 0	CSC 0	Area No. _____
Medical Record No. _____	Family Account No. _____		Purchaser No. _____
Date Received _____	Status: 0 Approved 0 Denied		Effective Date _____

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FORM OF AFFIDAVIT

This form is for applicants with an employer who has 50 or fewer employees and will be paying for or reimbursing the applicant for all or part of his or her insurance premiums.

Applicant information:

_____			() _____
Last name			Home phone number
_____			() _____
First name	MI		Work phone number
_____		Apt./Unit #	_____
Street address			Date of birth
_____	State	ZIP	
City			

Have your employer (or his or her representative) sign this affidavit to certify that your employer has not had a small group health benefit plan providing coverage to any employee in the past 12 months.

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

Or send it by secure fax to **1-866-920-6471**.

The undersigned officer or principal of the employer certifies that:

1. The employer is a small business employer as defined in § 10-16-102(40), C.R.S., with 50 or fewer eligible employees.
2. The employer has not had in place a small group health benefit plan for the 12 months prior to the execution of this affidavit.
3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Employer information:

Company		

Street address		
_____	State	ZIP
City		

X	_____
Signature	Date

_____	_____
Printed name	Position