

By signing below, I seek acceptance in The Kaiser Permanente Bridge Program. This Agreement is titled *The Kaiser Permanente Bridge Program* and contains the appropriate benefit schedule. I understand this Agreement can be obtained from Kaiser Permanente. I hereby authorize any physician, hospital or other health care provider and any insurer to furnish Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and The Southeast Permanente Medical Group, Inc. (Medical Group) with any information regarding the health and treatment of each person covered by this application. I agree to promptly furnish or cause to be furnished promptly upon request from Health Plan all authorizations and consents to the release of all medical records or confidential medical information from the custody or control of other health care providers and insurers as permitted by law in order to verify information contained in this application. I understand that failure to provide such authorizations and consents in a timely manner could result in the rejection of this application or termination from Health Plan.

I also understand and agree that whenever necessary in the administration of benefits under the Agreement or any other health care coverage, to investigate and settle claims, or to conduct quality assurance, peer review or utilization review, Health Plan may discuss with Medical Group medical information related to this application.

I also consent to the assignment of benefits to Health Plan which I may have in circumstances where a party other than Health Plan may be responsible for all, or a portion of, the services provided to me.

I also authorize Health Plan and Medical Group to exchange medical information regarding any person included under my coverage and to provide such information to other health care providers and to insurers as necessary for the provision of care, the administration of the Agreement and the settlement of claims from the date this authorization is signed.

In addition, I authorize Kaiser Permanente to notify the referring agency of my acceptance or denial into *The Kaiser Permanente Bridge Program*. I understand that this program is limited to a one time participation for a maximum of 24 months.

IMPORTANT: Please read the conditions above, and sign and date below. **All applications MUST be signed and dated. I have read and understand all of the above conditions and terms.**

_____ Signature of Primary Applicant	_____ Date	_____ Signature of Parent or Guardian	_____ Date
_____ Signature of Spouse	_____ Date	_____ Print Parent/Guardian Name	

Mail the completed application in the enclosed postage paid envelope to: *The Kaiser Permanente Bridge Program*
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

The Kaiser Permanente Bridge Program Application

Kaiser Foundation Health Plan of Georgia, Inc.

INSTRUCTIONS:

Please print clearly using a blue or black ink pen. If the question is not applicable write "N/A" or "None." Both sides of each page must be completed. If more space is needed, attach a separate page. If you have questions, call (404) 364-7001 and speak with a Kaiser Permanente Representative.

To avoid delays, please go through the application thoroughly to make sure ALL of the questions have been answered and the application has been SIGNED where required.

I. PARTNER INSTRUCTIONS

- Verify that the applicant has filled out Section I and the **first question** of Section III, prior to proceeding with the financial review.
- With the applicant, fill out Section II of the application. Make sure that the applicant signs at the bottom of Section II, where indicated.
- Based on the financial review, determine where the applicant's household falls on the current Federal Poverty Guidelines.
- Fill out and sign the "For Office Use Only" area in Section II and Section III.
- Keep Section I and Section II for your records. Return Section III, Section IV, and Section V to the Applicant to complete.

II. APPLICANT INSTRUCTIONS

- Fill out Section I and the **first question** of Section III BEFORE meeting with the Agency representative.
- With the Agency representative, complete Section II of the application and sign where indicated.
- Complete Section III and Section IV for yourself and each member of your family applying for coverage. Be sure and answer ALL QUESTIONS carefully and accurately for **each person** applying for coverage.
- Indicate in Section V if you would like to make your monthly payment by automatic draft or coupon. **Be sure to read and sign the back page.**
- Return the completed and SIGNED application to Kaiser Permanente using the self-addressed return envelope.
- You will be notified of your application status and your monthly premium if accepted.

Section I — To be completed by applicant.

1. Participant's Name: _____

2. Participant's Address: _____

City: _____ State: _____ ZIP Code: _____

3. Date of Birth: _____ Male Female

4. Telephone Number: (W) _____ (H) _____

5. Social Security or Tax ID Number: _____

6. Marital Status: Single Married Divorced Widowed

7. Number of people in your household _____

8. Please complete the following information for each family member:

Family Members (excluding yourself)

Name _____ Relationship _____ Date of Birth ____/____/____

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N

Name _____ Relationship _____ Date of Birth ____/____/____

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N

Name _____ Relationship _____ Date of Birth ____/____/____

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N

Name _____ Relationship _____ Date of Birth ____/____/____

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N

Name _____ Relationship _____ Date of Birth ____/____/____

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N

9. Are you applying for health care coverage for yourself? Y N

Number of people (other than yourself) applying for membership in *The Kaiser Permanente Bridge Program* _____

Section II: Financial Information — To be completed by agency with applicant

Monthly Income

	<i>Employer's name, address, and phone (if applicable)</i>	<i>Monthly Salary</i>
For yourself:	_____	\$ _____

For spouse (if applicable):	_____	\$ _____

For other dependents:	_____	\$ _____

	Total Salaries:	\$ _____
Child support received by you and/or your spouse		\$ _____
Other Income (Source): _____		\$ _____
	Total Monthly Income:	\$ _____

Liquid Assets

Maximum liquid assets — \$5,000 excluding primary residence and a car; \$2,000 for each additional family member

Cash on hand:	_____	\$ _____
	<i>Name of bank, account number</i>	
Other:	_____	\$ _____
	<i>(e.g., stocks, bonds, certifications of deposit, money market accounts)</i>	
	Total Liquid Assets:	\$ _____

Other financial information relevant to your membership status:

FOR OFFICE USE ONLY

I have reviewed the financial information of _____ (applicant's name, printed) and have determined that household income is _____ % of the Federal Poverty guidelines and that the liquid assets of the applicant and his/her dependents do not exceed the guidelines established by *The Kaiser Permanente Bridge Program*.

Signature of Agency Representative _____

Printed Name _____ Date _____

By signing below, I seek acceptance in The Kaiser Permanente Bridge Program. I certify that the foregoing answers are true and complete regarding my financial status. I will advise the participating agency immediately of any changes in my name, address, phone number, family income, or family size. I also agree that I have submitted all information voluntarily and I consent to the release of such information by third parties to the participating agency and Kaiser Permanente for purposes of verifying the data submitted. In addition, I authorize Kaiser Permanente to notify the referring agency of my acceptance or denial into The Kaiser Permanente Bridge Program. I understand that this program is limited to a one time participation for a maximum of 24 months.

Applicant's or Parent's or Guardian's Signature _____ Date _____

Section III: Health Care Information — To be completed by applicant

The Kaiser Permanente Bridge Program

NOTE: Applications must be dated within 60 days of your requested effective date. Your payment must be received prior to final processing.

To be Completed by Agency	Agency # _____
Meets Liquid Asset Guidelines <input type="checkbox"/> Y <input type="checkbox"/> N	
Federal Poverty Guidelines:	175% or less _____
	176% to 250% _____
Income _____	
Agency Name _____	
Agency Rep Signature _____	
Printed Name _____	
Date _____	

Instructions:

- n Please answer all questions completely to ensure timely processing of application.
- n Use only black or blue ink.
- n Completely fill in the bubbles and mark an "x" in the boxes (do not draw lines down the column). Example: X N
- n Clearly print inside the boxes using capital letters only.

1. I hereby apply for membership in *The Kaiser Permanente Bridge Program* based upon the following:

(Select One) Mr. Mrs. Ms. Miss (Select One) Single Married Widowed Divorced

or Adding dependent(s)

Primary Applicant Name - Last	_____	First	_____	MI	_____
Address	_____	Apt. #	_____	City	_____
			_____	State	_____
				ZIP	_____
Home Phone	_____	Work Phone	_____	Health Record Number	_____

Is the billing address different from the address listed above? Y N If yes, please list billing address below:

Billing Street Address	_____	Apt. #	_____	City	_____
			_____	State	_____
				ZIP	_____

Primary Applicant

	Birthdate	Social Security #	Sex
	MM / DD / YY	- -	

Spouse

Last Name	First Name	MI	Birthdate	Social Security #	Sex
			MM / DD / YY	- -	

Dependent 1 Relationship — Son Daughter Other (_____)

Last Name	First Name	MI	Birthdate	Social Security #	Sex
			MM / DD / YY	- -	

Dependent 2 Relationship — Son Daughter Other (_____)

Last Name	First Name	MI	Birthdate	Social Security #	Sex
			MM / DD / YY	- -	

Dependent 3 Relationship — Son Daughter Other (_____)

Last Name	First Name	MI	Birthdate	Social Security #	Sex
			MM / DD / YY	= =	

2. Are you eligible for any health insurance, through an employer, Medicaid, Medicare, or Peachcare? Y N

3. Are your dependents eligible for health insurance, through an employer, Medicaid, Medicare, or Peachcare? Y N

If yes, who is eligible for other coverage: _____

4. How long have you been without health insurance? (Optional)

1-6 months 6 months-1 year 2-3 years 4-5 years Over 5 years Never had health insurance

5. In the past have you or a family member ever had health insurance through: (Optional)

Kaiser Permanente Other private health insurance Medicaid Peachcare

Other _____

6. Is there any other information relevant to your membership status? (Optional)

7. Have you or any of your dependents been hospitalized or had medical expenses in excess of \$7,500 in the past 12 months? Y N

If yes, explain: _____

8. Primary language spoken: _____

Section IV: Applicant Medical Information — To be completed by applicant.

Please print the name of the family member designated as self, spouse, dependent 1, dependent 2, and dependent 3.

Self Current Doctor's Name _____

Address _____ Phone () _____

Spouse Current Doctor's Name _____

Address _____ Phone () _____

D1 Current Doctor's Name _____

Address _____ Phone () _____

D2 Current Doctor's Name _____

Address _____ Phone () _____

D3 Current Doctor's Name _____

Address _____ Phone () _____

Section V: Payment Information — To be completed by applicant.

Choose your monthly payment option:

AUTOMATIC DRAFT PLAN.

This payment method is your most convenient and reliable option. Payments are automatically deducted from your checking or savings account on the fifth day of each month. To enroll, simply read and fill out the section below.

BE SURE TO INCLUDE A VOIDED CHECK.

Note: If you choose the automatic draft plan as your payment option, you are still required to send your first month's premium along with a voided check. The automatic draft plan takes effect in your second month of coverage.

I hereby authorize Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) to debit my checking or savings account with the financial institution named below. If a debit will differ from that of the previous month's debit, Health Plan will notify me in writing at least seven days in advance of the change.

This authority is to remain in full force and effect until Health Plan has received written notification from me of its termination in such time and in such manner as to afford Health Plan reasonable opportunity to act on it. (Must give Health Plan 30 days.)

If an entry is erroneously initiated by Health Plan to my account, I have the right to have the amount of the entry credited to my account. However, I must give the financial institution a written notice within 15 days explaining that the entry was in error.

Bank Name: _____ Member (Depositor) Account Number: _____

Bank Address: _____ Type of account (check one) Savings Account Checking Account Other

Member Name(s): _____ (Please Print)

Signed: _____ (Member Signature)

Date: _____ Signed: _____ (Depositor Signature)

Date: _____ Signed: _____ (2nd Depositor Signature if Joint Account)

PAYMENT BY CREDIT CARD.

Your credit card will be charged for your/your family's first month's premium. Also each month's premium will be automatically charged to your credit card at the beginning of every month unless you arrange another form of payment by calling 866-238-2262. Your credit card will be charged only if you are accepted for membership.

Type of card: _____ Credit card Number: _____

Name as it appears on card: _____ Expiration date: _____

Signature: _____

INVOICE.

You will receive a monthly invoice from Kaiser Permanente. Payment is due on or before the first day of each month. Delinquent payments may lead to termination of coverage pursuant to the terms of the membership agreement. If you are ever terminated for nonpayment, Kaiser Permanente does not allow entrance back into any of its individual plans. Note: if you choose the Payment by Monthly Invoice option, you are still required to send your first month's premium. If you do not choose a payment method, you will automatically receive a monthly invoice.