Child Health Program Instruction Guide

This document provides instructions on how to apply for Kaiser Permanente’s Child Health Program (CHP).

Required documents

- Kaiser Permanente for Individuals and Families (KPIF) Application for health coverage
- Kaiser Permanente Subsidy Eligibility form
- Proof of income per the instructions on the Subsidy Eligibility form

Steps

1. Fill out the KPIF Application
2. Fill out Kaiser Permanente’s Subsidy Eligibility form. Be sure to include proof of income.
3. Mail completed documents to Kaiser Permanente:
   Charitable Health Coverage Operations
   Kaiser Permanente
   P.O. Box 12904
   Oakland, CA 94604

   Please do not send personal checks, money orders, or cash. If you owe any money, you will receive a bill after you are approved for enrollment in CHP.

Please note:

- Submission of these documents does not guarantee enrollment in CHP. You must meet eligibility requirements to be approved for CHP. Please visit http://info.kp.org/childhealthprogram to learn more.

- If you are not accepted for Kaiser Permanente's CHP and still want to purchase a Kaiser Permanente Platinum 90 HMO plan, or any other Kaiser Permanente Individual and Family plan, on your own, please call our National Direct Sales Center at 1-800-307-5945, or visit www.buykp.org.
**Step 1: Fill out the KPIF Application**

A screen shot of the KPIF application is included below. Instructions to complete the application are located in the left margin.

Please note, you do not need to complete any of the sections highlighted in grey as they do not apply to your application.

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**Kaiser Permanente**

**Application for health coverage**

<table>
<thead>
<tr>
<th>Who can use this application?</th>
<th>You may use this enrollment application to apply for individual or family coverage provided by Kaiser Permanente for Individuals and Families (KPIF), a business unit of Kaiser Foundation Health Plan, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If you want coverage for your family on the same Kaiser Permanente plan, please complete one application for the family.</td>
</tr>
<tr>
<td></td>
<td>• If a family member wants a different health plan, he or she must complete a separate application.</td>
</tr>
<tr>
<td></td>
<td>• To be eligible for Kaiser Permanente coverage, you must live in our California service area.</td>
</tr>
<tr>
<td></td>
<td>• If you qualify for federal financial assistance to help pay for copayments, coinsurance, deductibles, or premiums, do not complete this form. You must apply for coverage through Covered California at coveredca.com.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apply faster online</th>
<th>• You can apply faster online at buykp.org/apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If you would like to communicate with us electronically, please apply online and set up a secure email account.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Things to remember</th>
<th>• Please answer all questions and type or print using ink only.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the first of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the first of the month after the next month.</td>
</tr>
<tr>
<td></td>
<td>• If you are applying during a special enrollment period, be sure to follow all the instructions in the “When and how to enroll in your plan” section in the Enrollment Guide.</td>
</tr>
<tr>
<td></td>
<td>• To avoid being double billed, if you are enrolled in a plan through Covered California, you must cancel your current plan on or before the effective date of your new plan.</td>
</tr>
<tr>
<td></td>
<td>• Make sure your application is complete, signed, and includes your first month’s premium payment. If your application is incomplete or does not include your first month’s premium payment, it may delay your enrollment effective date or your application may be canceled.</td>
</tr>
<tr>
<td></td>
<td>• Send your complete, signed application and payment by mail or fax:</td>
</tr>
<tr>
<td></td>
<td>Mail your signed application to:</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente California Service Center – KPIF</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 23219, San Diego, CA 92193-9921</td>
</tr>
<tr>
<td></td>
<td>Or send it by secure fax to:</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente for Individuals and Families: 1-866-816-5139</td>
</tr>
<tr>
<td></td>
<td>• For help completing this application, please call 1-800-494-5314.</td>
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<tr>
<td></td>
<td>• We will provide language assistance at no cost to you.</td>
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<tr>
<td></td>
<td>• If you are working with a broker, please call him or her for assistance.</td>
</tr>
</tbody>
</table>

| Need help? | • If you qualify for federal financial assistance to help pay for copayments, coinsurance, deductibles, or premiums, do not complete this form. You must apply for coverage through Covered California at coveredca.com. |

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If you are applying outside of Open Enrollment please visit: http://info.kp.org/childhealthprogram to learn more about the documentation you are required to submit.
### Step 2: Choose Your Health Plan

Choose one Kaiser Permanente health plan. If any family members are applying for different health plans, please submit a separate application form for each plan.

<table>
<thead>
<tr>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Kaiser Permanente – Bronze 60 HSA 3500/30</td>
<td>○ Kaiser Permanente – Silver 70 HMO</td>
<td>○ Kaiser Permanente – Gold 80 HMO</td>
<td>○ Kaiser Permanente – Platinum 90 HMO</td>
</tr>
<tr>
<td>○ Kaiser Permanente – Bronze 60 HMO</td>
<td>○ Kaiser Permanente – Silver 70 HMO 1250/40</td>
<td>○ Kaiser Permanente – Gold 80 HMO 0/30</td>
<td></td>
</tr>
<tr>
<td>○ Kaiser Permanente – Bronze 60 HSA</td>
<td>○ Kaiser Permanente – Silver 70 HSA 1500/20%</td>
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</tbody>
</table>

**MINIMUM COVERAGE PLAN**

We also offer a minimum coverage plan, a high-deductible plan option for applicants under age 30 and certain persons age 30 and older. If you or any family members are age 30 or older, each person may only apply for this plan if you submit with your completed application a certificate of exemption from Covered California for each person that indicates lack of affordable coverage or financial hardship.

- ○ Kaiser Permanente – Minimum Coverage

For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment materials. To request a copy of the Membership Agreement for a particular plan, please call 1-800-464-4000 or contact your broker.

### Step 3: Choose Your Optional Dental Plan

Dental coverage is included in your health plan for all members age 18 and younger. Optional adult dental coverage is available for an additional monthly charge. For adults age 19 and older on January 1, 2015, Kaiser Permanente offers an optional dental plan. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California, one of the nation’s largest and most experienced dental benefits providers. Please choose 1 option below:

- ○ Yes, I would like to enroll in the optional Dental Insurance Plan. By electing to enroll, I agree to participate in the Consolidated Group One-Life Trust, which holds the KPIC Group Dental Policy.
- ○ No. I am not interested in optional dental coverage.

"If you qualify for federal financial assistance, do not use this form. We can help you apply through Covered California.

### Step 4: Enter Your Information

**Primary applicant** In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

<table>
<thead>
<tr>
<th>Name (first, middle, last)</th>
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<tbody>
<tr>
<td>Social Security number</td>
</tr>
<tr>
<td>Date of birth (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Medical record number (if any)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street address (no P.O. boxes, please)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apt. number</td>
</tr>
<tr>
<td>Same as billing address?</td>
</tr>
<tr>
<td>○ Yes ○ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
<th>County</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Main phone (   ) -</th>
<th>Other phone (   ) -</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preferred language spoken (if not English)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred language read (if not English)</td>
</tr>
</tbody>
</table>

**Spouse/Domestic Partner to Be Covered** A domestic partner is a person registered and legally recognized as your domestic partner by California.

<table>
<thead>
<tr>
<th>Name (first, middle, last)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security number</td>
</tr>
<tr>
<td>Date of birth (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Medical record number (if any)</td>
</tr>
</tbody>
</table>

The child to be covered is the Primary Applicant. If you have more than one child to be covered, the primary applicant can be any one of the children.

Social Security number is optional.
If there are more children to be covered, add their information here. Do not repeat the primary applicant’s information.

If you are applying for more children, photocopy this page and provide the information requested.

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**Dependents to Be Covered**

<table>
<thead>
<tr>
<th>Name (first, middle, last)</th>
<th>Relationship to primary applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (M/F)</td>
<td>Social Security number</td>
</tr>
<tr>
<td>Name (first, middle, last)</td>
<td>Relationship to primary applicant</td>
</tr>
<tr>
<td>Gender (M/F)</td>
<td>Social Security number</td>
</tr>
<tr>
<td>Name (first, middle, last)</td>
<td>Relationship to primary applicant</td>
</tr>
<tr>
<td>Gender (M/F)</td>
<td>Social Security number</td>
</tr>
<tr>
<td>Name (first, middle, last)</td>
<td>Relationship to primary applicant</td>
</tr>
<tr>
<td>Gender (M/F)</td>
<td>Social Security number</td>
</tr>
</tbody>
</table>

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**Step 5: Identify Financially Responsible Party**

To be completed by the parent or legal guardian if the applicant is under age 18, or by the financially responsible party if this is someone other than the primary applicant.

<table>
<thead>
<tr>
<th>Name (first, middle, last)</th>
<th>Gender (M/F)</th>
<th>Date of birth (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same address as primary applicant? (Yes/No)</td>
<td>Relationship to applicant: (Parent/Legal guardian/Spouse/Domestic partner/Other)</td>
<td></td>
</tr>
<tr>
<td>Street address (no P.O. boxes, please)</td>
<td>Apt. number</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP</td>
</tr>
<tr>
<td>Main phone</td>
<td>Other phone</td>
<td>Preferred language spoken (if not English)</td>
</tr>
</tbody>
</table>

**Step 6: Choose an Authorized Representative (if you have one)**

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application. This person is called an authorized representative.

| Name of authorized representative (first, middle, last) | Apt. number |
| Street address (no P.O. boxes, please) | |
| City | State | ZIP | County |
| Phone | |

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on matters related to this application.

Primary applicant or financially responsible party (parent or legal guardian for applicants under 18) Date (mm/dd/yyyy)
Step 7: Sign the Application Agreement

Important: All applicants and dependents 18 or older must read and sign below. If the primary applicant is younger than 18, then his or her parent or legal guardian must sign. By signing, the financially responsible party agrees to be responsible for paying all premiums, copayments, coinsurance, and deductibles for all the applicants listed on this form. If signatures are missing, we cannot continue processing the application.

All faxed and mailed correspondence must be signed and dated by the applicant or someone legally authorized to act on his or her behalf. The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call 1-800-464-4000.

- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- I know that discrimination isn’t permitted on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, or religion. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file or healthhelp.ca.gov or dfeh.ca.gov or www.insurance.ca.gov.

Step 8: Sign the Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Membership Agreement.

Step 9: Enter Details for First Month’s Premium Payment

Your application must be accompanied by payment for your first month’s premium. If your payment or payment information is missing or incomplete, your application may be delayed or canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Do not send cash through the mail.

Billing Information

Complete the following information for the financially responsible party. The financially responsible party is the primary applicant unless someone else is identified in Step 5 as the financially responsible party.

Name of financially responsible party (first, middle, last) | Payment amount for your first month’s premium
---|---

NOT APPLICABLE
Step 9: Enter Details for First Month's Premium Payment

Your application must be accompanied by payment for your first month’s premium. If your payment or payment information is missing or incomplete, your application may be delayed or canceled. You may submit payment by check, money order, electronic payment, credit card, or debit card. Do not send cash through the mail.

Billing Information
Complete the following information for the financially responsible party. The financially responsible party is the primary applicant unless someone else is identified in Step 5 as the financially responsible party.

Name of financially responsible party (first, middle, last) Payment amount for your first month’s premium

Street address (no P.O. boxes, please) Apt. number
City State ZIP

Payment Options
Check your preferred payment option below and complete that section.

☐ CREDIT/DEBIT CARD  If you are paying by credit or debit card, please complete the following information:

Credit/Debit card information: ☐ Credit ☐ Debit ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Cardholder’s name as it appears on card
Credit/Debit card number Expiration date (mm/yyyy)
Cardholder signature Date (mm/dd/yyyy)

☐ ELECTRONIC PAYMENT
I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ☐ Checking account ☐ Savings account
Routing number Account number
(At the bottom of your check, you will see 3 groups of numbers. The first group of numbers is your routing number; the second group is your account number.)
Account holder’s full name (print) Account holder signature

☐ CHECK ☐ MONEY ORDER
If you are paying by check or money order:

• Make the check or money order payable to Kaiser Permanente for Individuals and Families.
• Write the name of the primary applicant on the check.
• Mail to the address listed on page 1.

Step 10: Sign Up For Automatic Monthly Payments

For your convenience, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

Billing Information
Same billing as first month’s premium? ☐ Yes ☐ No If no, complete the following information for the financially responsible party.

Name of financially responsible party (first, middle, last)
Street address (no P.O. boxes, please) Apt. number
City State ZIP

Payment Options
I understand that if I have chosen the option to set up a recurring premium payment schedule and later wish to cancel or update that schedule, I must do either of the following:
1. Go to kp.org/payonline and follow instructions to create a profile and cancel or update my recurring payment schedule.
2. Call the KFHP Member Service Contact Center at 1-800-464-4000 to obtain assistance from a customer service representative to cancel or update my recurring payment schedule.

☐ DEDUCT FROM MY BANKING ACCOUNT
By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on the first day of each month and agree to the terms outlined above.

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit: ☐ Checking account ☐ Savings account
Routing number Account number
Step 10: Sign Up For Automatic Monthly Payments

For your convenience, you can choose to make automatic monthly payments. This is an optional service that allows you to automatically pay your monthly premium payment electronically. Fill out this page to select this option.

Billing Information

Same billing as first month's premium? 

[ ] Yes [ ] No

If no, complete the following information for the financially responsible party.

Name of financially responsible party (first, middle, last)

Street address (no P.O. boxes, please)

Apt. number

City State ZIP

Payment Options

I understand that if I have chosen the option to set up a recurring premium payment schedule and later wish to cancel or update that schedule, I must do either of the following:

1. Go to kp.org/payonline and follow instructions to create a profile and cancel or update my recurring payment schedule.
2. Call the KFHP Member Service Contact Center at 1-800-464-4000 to obtain assistance from a customer service representative to cancel or update my recurring payment schedule.

[ ] DEPENDENT ON MY BANKING ACCOUNT

By filling out this section, you are requesting that your premiums be automatically deducted from either your checking account or your savings account on the first day of each month and agree to the terms outlined above.

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Please debit:

[ ] Checking account

[ ] Savings account

[ ] OFFICE DEPARTMENT

[ ] DEPENDENT ON MY CREDIT CARD

By filling out this section, you are requesting that your premiums be automatically charged to your credit card on the first day of each month, and agree to the terms outlined above.

Credit card information: 

[ ] Visa [ ] MasterCard [ ] Discover [ ] American Express

Cardholder’s name as it appears on card

Credit card number

Expiration date (mm/yyyy)

Cardholder signature

Date (mm/dd/yyyy)

[ ] I AM NOT INTERESTED IN THE AUTOMATIC PAYMENT OPTION

By selecting this option, you will automatically receive a monthly invoice from Kaiser Permanente for Individuals and Families.

Step 11: Enter Information For Your Agent/Broker/KPIF Representative

(if you have one)

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. We will not consider your application to be complete until your agent/broker/KPIF representative completes this section. A Kaiser Permanente representative includes any KPIF representative who has provided you with assistance.

Agent/Broker/KPIF representative (first, middle, last)

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.

Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

To be completed by your Kaiser Permanente-appointed agent/broker/KPIF representative after completion of this application:

Notice to agent, broker, KPIF representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate.

I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

[ ] Yes [ ] No

Agent/Broker/KPIF representative

[ ]

Date (mm/dd/yyyy)

Agent/Broker/KPIF representative (first, middle, last) (please print)

Kaiser Permanente-appointed broker identification number

Street address

Apt. number

City State ZIP

Phone Fax Email address

[ ]

[ ]

[ ]

[ ]

Step 2. Complete Kaiser Permanente’s Subsidy Eligibility form. Please be sure to include proof of income

Step 3. Mail completed documents to Kaiser Permanente:

Charitable Health Coverage Operations

Kaiser Permanente

P.O. Box 12904

Oakland, CA 94604

Thank you.