

KPS is a health care service contractor licensed in the state of Washington and currently marketing in Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom Counties

Please review all three pages of the application, complete sections 1 through 5 AND the enclosed health questionnaire. If you are working with an agent, they must complete section 6. This application will be returned if not completed in full. It must be signed on page 2 and page 3 by the applicant and legal spouse (if applying).

YOU MUST INCLUDE YOUR PAYMENT FOR THE FIRST MONTH'S PREMIUM WITH THIS APPLICATION. Make your check or money order payable to KPS Health Plans.

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

1. General Information

Applicant's Name (last, first, middle initial)			Social Security No.	
Street Address		City	State	Zip
Mailing Address (if different)		City	State	Zip
Occupation	Employer	Home Telephone	Work Telephone	

Choose one:

New Subscriber Adding Dependent(s) Transferring from a KPS or other medical plan

If transferring, please indicate plan name and ID number: _____

Effective date of previous contract: _____ Termination and/or paid through date: _____

If you are covered on any group plan or other individual plan (including Medicare or CHAMPUS) which you intend to continue, please provide the plan name and identification number: _____

2. Indicate Plan Choice

<input type="checkbox"/> Sound Harbor Classic \$500 Deductible <input type="checkbox"/> Sound Harbor Essential \$1,500 Deductible <input type="checkbox"/> Sound Harbor Essential \$2,500 Deductible <input type="checkbox"/> Sound Harbor Essential \$5,000 Deductible	The Healthy Investor™ - Health Savings Account (HSA) <input type="checkbox"/> \$1,600 Individual/\$3,200 Family Deductible <input type="checkbox"/> \$2,600 Individual/\$5,150 Family Deductible
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3. List name, sex, and birth date for your self and all family members to be covered. Applicant and legal spouse must not be eligible for Medicare; children must be under age 23 (under age 25 on The Healthy Investor™ plans), unmarried, and eligible as your dependents.

	LAST NAME	FIRST NAME	M.I.	SEX		BIRTH DATE		
				M	F	Month	Day	Year
Applicant								
Spouse								
Child								
Child								
Child								
Child								
Child								

4. Please answer the following questions so we can determine whether your previous health plan was similar. This will allow us to waive the pre-existing conditions or limitations on your new plan. (Please see the Application Instructions for more information on pre-existing conditions and a definition of creditable coverage and eligible individual.)

a.) Did your previous policy cover prescription drugs?	___ YES ___ NO
b.) Did your previous policy cover maternity?	___ YES ___ NO
c.) Have you had health coverage within the past 3 months?	___ YES ___ NO

5. **Smoker/Non-Smoker Certification Statement**

I have used tobacco products during the prior twelve months.	___ YES ___ NO
My Spouse has used tobacco products during the prior twelve months.	___ YES ___ NO
_____	_____
Applicant Signature	Date
_____	_____
Spouse Signature (if applying)	Date
<p>If only one of you qualifies for the non-smoker rates, apply for separate contracts. Otherwise, you will both be charged the smoker rate.</p> <p>PLEASE NOTE: KPS reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker rates.</p>	

6. **Agent Information**

<u>FOR AGENT USE ONLY</u>				
AGENT VERIFICATION:				
Please complete the following <u>AFTER</u> the applicant has completed the application and health questionnaire.				
To the best of my knowledge, the answers on this application and health questionnaire are complete and accurate.				
Agent/Agency Name - as licensed with KPS (please print)	Agent Signature		Agent No.	
Northwest Indemnity Services Inc			05401	
Mailing Address	City	State	Zip	Telephone No.
PO Box 2168	Battle Ground	WA	98604	360-687-3002



PLEASE REMEMBER TO COMPLETE THE ENCLOSED HEALTH QUESTIONNAIRE

CONDITIONS OF ENROLLMENT

PLEASE READ CAREFULLY

- I am applying for enrollment with KPS Health Plans for myself and the family members listed.
- I certify that all statements and answers on this application and the health questionnaire are complete and true and that all rights to service are void if found false or incomplete.
- I understand and agree that discovery of any material information omitted by or for any person listed on this application or the health questionnaire may result in termination of the contract retroactively.
- I understand and agree that coverage will begin on the first of the month after this application is approved by KPS Health Plans OR the first of _____ (indicate month only if you are requesting an effective date up to 90 days from date of application).
- I further understand that I must notify KPS Health Plans immediately of any change in my/our health status that may occur between now and the effective date that I have requested.
- I understand that receipt of my money (check, or money order) does not constitute enrollment in the plan for which I am applying.
- I understand that the plan for which I am applying has a nine (9) month waiting period for pre-existing conditions (other than prenatal care and newborns), unless I am transferring from another KPS plan or have been continuously enrolled (a gap of no more than 3 months) in a plan with equivalent or greater benefit coverage within the nine (9) month period immediately preceding the effective date of this contract. *Please see Application Instructions for more information on pre-existing conditions and definitions for creditable coverage and eligible individual.*
- I understand that the plan I am applying for has a waiting period for certain listed benefits.
- I, the undersigned, have read and personally completed all of the requested information on this form. (If not, please attach a letter of explanation.)

PERMISSION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I hereby grant permission for KPS Health Plans to release and receive any and all medical records, permitted by law, for purposes of treatment, payment and health care operations for anyone making application, enrolled hereunder, or added hereafter. This permission shall become effective immediately and shall remain in effect as long as necessary to enable KPS Health Plans to process the application and claims

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

IMPORTANT: Before you sign the application, be sure that you read and understand the conditions listed above.

Applicant's Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____

Parent/Legal Guardian Signature (if applicable) _____ Date _____

Please tell us how you heard about KPS:

____ Newspaper ____ Phone Book Yellow Pages ____ Phone Book White Pages
____ Friend ____ Agent ____ Other



health plans

**APPLICATION INSTRUCTIONS
AND WAITING PERIOD INFORMATION**

WHEN MAKING APPLICATION, IT IS IMPORTANT TO FOLLOW THESE INSTRUCTIONS IN ORDER TO PREVENT DELAYS IN THE EFFECTIVE DATE OF YOUR COVERAGE

1. Complete one three-page **APPLICATION FORM** in full for all family members and one **HEALTH QUESTIONNAIRE** for each family member to be covered. Each adult to be covered must sign page 2 and page 3 (adult subscriber may sign for children but not for spouse). Be sure to indicate your PLAN CHOICE.

DO NOT complete the health questionnaire if any of the following apply:

- a.) You are applying for medical insurance because you have used up all the available time on your COBRA coverage. In order for this exception to apply, you must be submitting your application for new coverage within 90 days from the date that your COBRA coverage ended.
 - b.) Your former employer, who provided you with health coverage, has gone out of business while you were on COBRA coverage, and you are applying for new individual coverage within 90 days from the date that coverage ended. *Please include a letter of verification from your employer or carrier.*
 - c.) You have moved from one part of Washington State to another, and the insurance carrier that you had does not offer medical coverage where you live now. In order for this exception to apply, you must be submitting your application for new coverage within 90 days from the time that you moved. *Please include a copy of a utility bill in your name from the prior address and a letter of verification from your prior carrier.*
 - d.) You are applying for new coverage because your doctor or other health care provider has stopped being a part of the provider network on your current individual medical plan. In order for this exception to apply:
 - Your doctor or provider must be participating in a KPS provider network;
 - You must have had some service from the provider during the 12 months before he or she left your current plan, and;
 - You must be submitting your application within 90 days from the day your provider left your current insurance carrier's network.
 - e.) Your employer normally employs fewer than 20 employees and is not required to offer COBRA coverage and you had at least 24 months of continuous group coverage before a qualifying event. *Please include a letter of verification from your employer.*
2. If you have been continuously enrolled in another health plan during the nine-month period immediately preceding your requested effective date with KPS, please submit your **CERTIFICATE OF CREDITABLE COVERAGE** provided by your former plan or other proof of prior coverage (e.g., pay stubs, Explanation of Benefits forms, benefit termination from Medicare and Medicaid, verification by a doctor or provider of your prior coverage).
 3. Return the form(s) **WITH PAYMENT FOR THE FIRST MONTH** in the envelope we have provided or to: KPS Health Plans, P.O. Box 339, Bremerton, Washington 98037-0039. We cannot process your application unless the premium payment is included.

If you wish to have subsequent payments directly transferred from your bank account, complete the AUTHORIZATION AGREEMENT FOR "SURE PAY" form and include it with the above. This will take several weeks to go into effect, so you will receive a bill in the interim.

Your completed application must be postmarked or delivered to KPS by the 20th of the month for coverage to be effective the first of the following month. If coverage is denied, you will be notified by mail and application materials will be included to apply for coverage under the Washington State Health Insurance Pool.

**PLEASE SEE THE OTHER SIDE OF THIS SHEET FOR INFORMATION REGARDING
WAITING PERIODS AND DEFINITIONS FOR PRE-EXISTING CONDITION EXCLUSION
AND CREDITABLE COVERAGE**

WAITING PERIODS: The benefits of this contract are subject to waiting periods as follows:

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

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

- (b) **Pre-existing Conditions:** During the first nine (9) months that a beneficiary is covered under the contract, benefits are not provided for treatment of any pre-existing condition that was present within six (6) months before the effective date of coverage.

NOTE: Under Washington State regulations, pre-existing conditions cannot be applied to prenatal care or newborns, including an adopted child if the child becomes covered within 60 days of birth or placement for adoption. Benefits will be provided for any formulas necessary for the treatment of phenylketonuria (PKU). Credit to the waiting period for pre-existing conditions will be given if the person is continuously enrolled (a gap of no more than 3 months) in a plan with equivalent or greater benefit coverage within the nine (9) month period immediately preceding the initial date of eligibility.

DEFINITION OF “PRE-EXISTING CONDITION EXCLUSION”: Pre-existing condition exclusion limits or denies benefits for a medical condition that existed before the date that coverage began. A “medical condition” is any physical or mental condition resulting from an illness, injury, pregnancy, or congenital malformation for which medical advice was given, for which a health care provider recommended or provided treatment, within six (6) months prior to the effective date of the plan.

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

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

Please complete the following form if you wish to have your monthly premium payment automatically withdrawn from your bank account. This is an optional free service for your convenience. "Sure Pay" allows KPS to arrange with your bank a transfer of sufficient funds on or about the 10th of each month for the following month's coverage. The funds transfer will appear on your monthly bank statement, and KPS will notify you in advance if there is to be any change in the amount of your premium.

PLEASE NOTE: **Payment for the first month's premium is required with your application.** After your application is approved, it may take approximately one month to complete the "Sure Pay" arrangement with your bank. If you receive any premium bills, it means the funds transfer process has not been completed and you should make the payment. The "Sure Pay" system will then take effect for the following months and you will no longer receive bills.

Authorization Agreement for "Sure Pay" Premium Payment

I hereby authorize KPS Health Plans to initiate funds transfers from my bank account listed below and authorize my bank* to honor these transfers.

I understand that this agreement will remain in effect until KPS Health Plans has received written notice from me that it should be cancelled. This notice shall be given two weeks prior to the next scheduled payment.

I have the right to stop payment of a transfer from my bank account to KPS Health Plans and must notify my bank at least two weeks before the scheduled payment date. Funds transfers are scheduled to be made on or about the 10th of each month, **prior to the month of coverage.**

NAME _____
(Please print as shown on your bank account) _____

KPS ID# _____
(If not issued yet, leave blank)

SIGNATURE _____

DATE _____

* As used herein, the term "bank" includes all types of financial institutions, including commercial banks, savings banks, savings and loans, credit unions, etc.

Please attached a **voided check** for the bank account from which you are authorizing "Sure Pay" transfers, and return via mail or in person to:

KPS
health plans

PO Box 339
400 Warren Avenue
Bremerton, Washington 98337
www.kpshealthplans.com