
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 about the application, contact your community partner or call (404) 364-3811 to speak with a Kaiser Permanente Bridge Program 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.

Section I — To be completed by applicant.

1. Applicant's Name: _____

2. Applicant's Address: _____

City: _____ State: _____ ZIP Code: _____

3. Date of Birth: _____ Male Female

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

5. E-mail Address: _____

6. Social Security or Tax ID Number: _____

7. Marital Status: Single Married Divorced Widowed

8. Number of people in your household _____

9. 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
(or Tax ID Number)

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

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N
(or Tax ID Number)

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

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N
(or Tax ID Number)

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

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N
(or Tax ID Number)

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

Social Security Number _____ — _____ — _____ Sex M F Health Coverage Needed? Y N
(or Tax ID Number)

10. 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 the 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; \$100,000 in retirement funds

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:

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 Kaiser Permanente and 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 a short term limited duration policy of insurance that will automatically expire in 24 months from the effective date of coverage. Upon acceptance into The Kaiser Permanente Bridge Program, the Health Plan may periodically confirm you are still meeting the subsidy eligibility requirements outlined in the EOC. If the Health Plan determines that you are no longer meeting the eligibility requirements, the Health Plan will terminate your coverage at the end of the month under The Kaiser Permanente Bridge Program. Consequently, under federal law, this policy is exempt from the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this policy is not subject to federal rules that otherwise guarantee renewability, guarantee issue, or waive pre-existing condition limitations and I hereby apply for coverage under this program with the understanding that these rights do not apply.

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. After 60 days, the application will expire and you will need to reapply.

INTERNAL USE ONLY – Bridge Program

To be Completed by Vendor Agency # _____

Meets Liquid Asset Guidelines Y N

Income _____

Vendor Name _____

Vendor Rep Signature _____

Printed Name _____

Date _____

Instructions:

- Please answer all questions completely to ensure timely processing of application.
- Use only black or blue ink.
- Completely fill in the bubbles and mark an “x” in the boxes (do not draw lines down the column). Example: X 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

Birthdate Social Security # Sex

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

Spouse

Last Name	First Name	MI	Birthdate MM/DD/YY	Social Security # - -	Sex
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Dependent 1 Relationship — Son Daughter Other ()

Last Name	First Name	MI	Birthdate MM/DD/YY	Social Security # - -	Sex
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Dependent 2 Relationship — Son Daughter Other ()

Last Name	First Name	MI	Birthdate MM/DD/YY	Social Security # - -	Sex
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Dependent 3 Relationship — Son Daughter Other ()

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

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:

Kaiser Permanente Other private health insurance Medicaid Peachcare

Other _____

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

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

Dependent 1

Current Doctor's Name

()

Address

Phone

Dependent 2

Current Doctor's Name

()

Address

Phone

Dependent 3

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 AND YOUR FIRST MONTH'S PREMIUM.

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
(Please attach a voided check) 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 on or about the 20th of each 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 required to send your first month's premium. If you do not choose a payment method, you will automatically receive a monthly invoice with this application.

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 a short term limited duration policy of insurance that will automatically expire in 24 months from the effective date of coverage. Upon acceptance into *The Kaiser Permanente Bridge Program*, the Health Plan may periodically confirm you are still meeting the subsidy eligibility requirements outlined in the EOC. If the Health Plan determines that you are no longer meeting the eligibility requirements, the Health Plan will terminate your coverage at the end of the month under *The Kaiser Permanente Bridge Program*. Consequently, under federal law, this policy is exempt from the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this policy is not subject to federal rules that otherwise guarantee renewability, guarantee issue, or waive pre-existing condition limitations and I hereby apply for coverage under this program with the understanding that these rights do not apply.

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	_____ Date
_____ Signature of Dependent Over Age 18	_____ Date	_____ Print Dependent Over Age 18 Name	_____ Date
_____ Signature of Dependent Over Age 18	_____ Date	_____ Print Dependent Over Age 18 Name	_____ Date

