

PO Box 339 | Bremerton, WA 98337 | 1-800-552-7114

Please answer all questions completely and accurately. Include signature of the Subscriber. Incomplete applications or applications submitted without signatures will be returned.

A waiting period may apply for pre-existing conditions, unless you had health insurance prior to enrolling in this KPS plan and the break in coverage does not exceed three (3) months. **Please provide us with a certificate of creditable coverage from your prior plan to have this waiting period waived or shortened** (all health plans are required to provide these Certificates to member(s)). Other proof of prior coverage may be a copy of the front and back of your prior plan's identification card, payroll check information showing a deduction for medical insurance coverage, Explanation of Benefits from your prior insurance carrier, benefit termination from Medicare or Medicaid, verification by a doctor or provider of your prior coverage, or any other relevant documents that exhibit periods of health coverage.

CHECK APPLICABLE BOXES

DATE OF CHANGE	MONTH:	DAY:	YEAR:
NEW ENROLLMENT			
<input type="checkbox"/> New Group	<input type="checkbox"/> New Employee	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Reemployment <input type="checkbox"/> COBRA <input type="checkbox"/> Plan Choice:
CHANGE IN ENROLLMENT (additional documentation may be required – see page 3 Special Enrollment Requirements)			
<input type="checkbox"/> Address	<input type="checkbox"/> Adoption/Placement for Adoption	<input type="checkbox"/> Name	<input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Newborn
<input type="checkbox"/> Court Ordered Coverage	<input type="checkbox"/> State Sponsored Coverage	<input type="checkbox"/> Loss of Other Coverage (provide reason):	

SUBSCRIBER - LAST NAME:	FIRST:	M.I.:	HOME PHONE:	WORK PHONE:
HOME (MAILING) ADDRESS - STREET & NUMBER:	APT. NO.:	CITY:	STATE:	ZIP:
EMPLOYER NAME/GROUP NAME:	DATE OF EMPLOYMENT:	CLASSIFICATION:		
(EMPLOYER USE) INTENDED EFFECTIVE DATE:	(EMPLOYER USE) GROUP NO.	KPS USE		

SUBSCRIBER: List family members to be covered by this plan. Dependent children listed below must meet criteria as stated in the KPS definition of "child." Fill out "Relationship" (i.e., son, daughter). If making enrollment changes, list everyone you want coverage for at this time. * *Social Security Numbers are required to be in compliance with the reporting guidelines of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.*

ADD	DROP	RELATIONSHIP TO SUBSCRIBER	LAST NAME:	FIRST:	M.I.:	DATE OF BIRTH			SEX		SOCIAL SECURITY NUMBER*
						M	D	Y	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	SELF									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER									
<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>										

IMPORTANT! Prior/Current Health Insurance Plan Information: Completing the following information may allow any applicable waiting periods for pre-existing conditions to be waived or shortened and will allow KPS to process your claims quickly and correctly. If prior coverage information is not provided, the full waiting period will apply. Please check the first box if you have no prior health coverage to report.

Prior/Current Health Insurance Information: Please provide the following information for any health insurance you, or anyone in your family had at any time during the three (3) months prior to your enrollment date in this plan. <input type="checkbox"/> No Coverage <input type="checkbox"/> Yes (complete the following)					
Who was covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent Children	<input type="checkbox"/> Date coverage began:	<input type="checkbox"/> Date coverage ended:
Plan Name:	Plan Phone Number:	Plan ID Number:			

List address of each child listed on page 1, if different from subscriber. List name and address of custodial parent of child(ren) to be covered, if applicable. This information is necessary to facilitate the processing of claims submitted on behalf of a dependent child not living with the subscriber.

1. CHILD'S NAME:	MAILING ADDRESS:	CITY:	STATE:	ZIP:
2. CHILD'S NAME	MAILING ADDRESS:	CITY:	STATE:	ZIP:
3. CHILD'S NAME	MAILING ADDRESS:	CITY:	STATE:	ZIP:
NAME (CUSTODIAL PARENT)	MAILING ADDRESS:	CITY:	STATE:	ZIP:

I hereby grant permission for KPS Health Plans to release and receive any and all medical records, as permitted by law, for purposes of treatment, payment and healthcare 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. I also agree that my employer/group may deduct from my pay the amount, if any, for coverage selected.

I apply for enrollment with KPS for myself and the listed dependents and certify that (a) to the best of my knowledge, we are eligible for the coverage requested; (b) I have reviewed the product information and understand the EXCLUSIONS, LIMITATIONS, and WAITING PERIODS stated therein; and (c) all information on this form is true, correct, and complete. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGNATURE:	DATE SIGNED:
------------	--------------

*Continue on other side***PROOF OF CREDITABLE COVERAGE:**

You may provide proof of creditable coverage to KPS by sending copies of a Certificate of Coverage from a prior plan, a copy of the front and back of your prior plan's identification card, payroll check information showing a deduction for medical insurance coverage, Explanation of Benefits from your prior insurance carrier, benefit termination from Medicare or Medicaid, verification by a doctor or provider of your prior coverage, or any other relevant documents that exhibit periods of health coverage.

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 coverage is creditable coverage, including coverage under the following:

- A group health plan
- A health insurance policy
- Part A or Part B of 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
- State Children's Health Insurance Program
- A health plan under the Peace Corps Act

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, or congenital malformation---for which medical advice was given, for which a health care provider recommended or provided treatment, within:

- Six months prior to date of enrollment on the plan (Small Group plans)
- Three months prior to date of enrollment on the plan (Large Group and Association plans)

In the case of enrollees under the age of 19, this Pre-existing condition exclusion does not apply.

Note: If you were required to complete an employer imposed probationary period, the pre-existing condition waiting period begins on the first day of your probationary period.

SPECIAL ENROLLMENT REQUIREMENTS:

KPS requires additional documentation when enrolling for the following life events:

- Court Ordered Coverage: Submit a copy of the court order.
- Loss of Other Coverage: Submit proof of involuntary loss of other coverage (e.g. Certificate of Health Plan Coverage, letter from prior employer, etc.).
- Adoption / Placement for Adoption: Submit a copy of adoption or placement documents.
- State Sponsored Coverage: Submit a copy of the Department of Social and Health Services Letter.
- Marriage: Submit a copy of the marriage certificate or Domestic Partnership state registration.

DEFINITION OF CHILD(REN):

- A natural child(ren), adopted child(ren), stepchild(ren) or other legally designated ward under the Limiting Age who is a dependent of the Subscriber or the Subscriber's Spouse;
- A child(ren) under the Limiting Age who is legally entitled to receive medical coverage as a result of a court order binding either the Subscriber or the Subscriber's Spouse, regardless of whether or not the Subscriber's Spouse has legal custody of the child(ren);
- A child(ren) who has reached the Limiting Age, or is older than the Limiting Age, is incapable of self-sustaining employment due to developmental disability or physical handicap, and is dependent upon the Subscriber or the Subscriber's Spouse for total or partial support and maintenance.

DOMESTIC PARTNERS:

- Coverage for State Registered Domestic Partners requires evidence of Domestic Partnership state registration (All Plans).
- Coverage for unregistered Domestic Partners requires submission of an "Affidavit of Domestic Partnership" (Large Group and Association Plans who have purchased the Domestic Partner Endorsement only).