

# Colorado Benefit Professionals, LLC

## Application Instructions For Kaiser Permanente Colorado

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Colorado Benefit Professionals, LLC for review along with the completed application. If you do not have access to a fax machine, send the completed application to Colorado Benefit Professionals, LLC along with the required first month's payment.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Kaiser Permanente Colorado** if you are not paying by credit card for the first month.

Mail completed application and check to:

**Colorado Benefit Professionals, LLC**

**Attn: New Enrollment**

**5617 Yarrow St.**

**Arvada, CO 80002**

Colorado Benefit Professionals, LLC will review your application for completeness and accuracy before we submit it to Kaiser Permanente Colorado for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 303-239-8794 or e-mail us at [winncp@qwest.net](mailto:winncp@qwest.net).

# Colorado Benefit Professionals, LLC

## FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Colorado Benefit Professionals, LLC**

**FAX# 303-239-8937**

Dear Colorado Benefit Professionals, LLC,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_



Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.



I will contact Colorado Benefit Professionals, LLC at 303-239-8794 to verify receipt of my application.

**\*\*I understand that Colorado Benefit Professionals, LLC will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Colorado Benefit Professionals, LLC. I will mail the original signed application to :

**Colorado Benefit Professionals, LLC**

**Attn: New Enrollment**

**5617 Yarrow St.**

**Arvada, CO 80002**

I will send the original application as soon as I have been contacted by Colorado Benefit Professionals, LLC with confirmation that my application has been received by fax and reviewed for completeness.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**II. BILLING INFORMATION (HEAD OF HOUSEHOLD ONLY)**

Only the Head of Household must complete Section II - Billing Information and Section III - Family to be Covered.

1. Person to be billed

Last Name

First Name

Mr.  Mrs.  
 Miss  Ms.

M.I.

Date of Birth

Social Security Number or Taxpayer I.D.

Street Address

Apt. No.

City

State

ZIP Code

2. Account Information

- Addition of a family member to an existing account
- New account
- Change from one plan design to another

3. For which plan would you like to apply?

- \$2,000 Deductible Plan with HSA Option (100%)
- \$2,000 Deductible Plan with HSA Option (80%)
- \$5,000 Deductible Plan (70%)
- \$2,000 Deductible Plan (70%)
- \$30 Copayment Plan
- \$20 Copayment Plan

4. Kaiser Permanente Medical Record Number:

5. Home Phone:

6. Work Phone:

**For applicants using an insurance broker**

7. Broker/General Agent Name:

Charles P. Winn

8. Broker/General Agent Number:

000454213

I understand that the broker of record may receive monetary and/or nonmonetary payments from the Health Plan and/or Kaiser Permanente Insurance Company (KPIC) in connection with the purchase of this health plan coverage.

**III. FAMILY TO BE COVERED (OTHER THAN HEAD OF HOUSEHOLD)**

**EACH PERSON IN THE FAMILY MUST COMPLETE A SEPARATE APPLICATION FOR MEMBERSHIP**

Relationship	Name - Last	First	M.I.	Date of Birth	Sex (M/F)	S.S.N.
Spouse	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____

The head of household (or subscriber) and spouse, if applying together, must complete, sign, and date this page for their applications to be considered complete.

**IV. BUSINESS GROUP OF ONE DETERMINATION FORM**

Please complete and sign this form to determine if you are a self-employed Business Group of One.

Self	Spouse	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you or your spouse either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you or your spouse have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that is sufficient to pay for the annual premiums for the Business Group of One's health benefit plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?

Please sign below

I, \_\_\_\_\_, attest that the answers to the questions contained in this form are true and correct.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, attest that the answers to the questions contained in this form are true and correct.

Signature of spouse \_\_\_\_\_ Date \_\_\_\_\_ Applicant or spouse's business \_\_\_\_\_

**If you or your spouse answered Yes to all four questions listed above, please complete and sign the following Business Group of One Disclosure Form.**

**V. BUSINESS GROUP OF ONE DISCLOSURE FORM**

Please read and sign the following disclosure required by Colorado law:

I, \_\_\_\_\_, meet the definition of a self-employed Business Group of One as attested to on the accompanying Business Group of One Determination Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group Business Group of One policy are limited to plan design, the carrier's overall cost and utilization trends (index rate), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

Applicant's name \_\_\_\_\_ Applicant's signature \_\_\_\_\_

Applicant's business \_\_\_\_\_ Date \_\_\_\_\_

**ALL APPLICANTS: PLEASE READ THE FOLLOWING INFORMATION  
AND SIGN IN THE SPACE BELOW**

If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member services representative at 1-800-634-4579 before signing this application.

**VI. HEALTH STATUS UPDATE**

You must immediately inform us if your health status or current medication changes at any time before your membership in Kaiser Permanente for Individuals and Families Plan becomes effective. Changes in health status may result in revocation of the approval for enrollment. Failure to inform us of such change can void your Health Plan membership. You can choose to update your application information by telephone **1-800-634-4579**, by fax 1-800-369-8010, or by writing to us at **Kaiser Foundation Health Plan, Individual Programs, 393 E. Walnut Street, LsRs-5, Pasadena, CA 91188-8539, Attention: Health Status Update**. All written and fax correspondence must be signed and dated by the subscriber.

**To the applicant:** You or your authorized representative may request a copy of your completed application. For more information, please call **1-800-634-4579**.

**VII. INSURANCE FRAUD WARNING**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**VIII. AUTHORIZATION TO REVIEW EXISTING INFORMATION**

I hereby authorize Kaiser Foundation Health Plan to review any existing Kaiser Permanente medical records and history of care provided to me or my dependents as members of Kaiser Foundation Health Plan for a period of up to 5 years preceding this application for membership in the Kaiser Permanente for Individuals and Families Plan. This authorization applies to all types of care including the diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, or AIDS-related condition, and is limited to information reasonably related to determining my/our eligibility for membership in the Kaiser Permanente for Individuals and Families Plan. I understand that Kaiser Foundation Health Plan will not redisclose any information received through this review except with my written consent or as permitted by federal and/or state laws and regulations. This authorization for review is effective during all times that my/our application and/or eligibility status are being considered. If accepted as a Kaiser Permanente for Individuals and Families Plan member, I further authorize Kaiser Foundation Health Plan, without limitation and including all categories of care stated above, to review my Kaiser Permanente medical records, including pharmacy records, for a period of up to 12 months following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application.

**IX. KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT**

Except for Small Claims Court cases, claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in the Colorado Revised Statutes, Section 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

**NOTE:** Any intentional misrepresentation of your current health status may void your coverage and the coverage of your family members. (If you are unsure of your medical condition, please ask your current or previous physician to clarify your specific condition.)

<b>To apply for membership, YOU <u>MUST</u> SIGN HERE</b>	
<b>X</b>	<b>Date</b>

Applicant's Signature if 18 or older or emancipated minor (otherwise, Parent/Legal Guardian signature required) **USE BLACK INK ONLY.**  
Please continue on page 5.

<b>For Office Use Only:</b>	PH 0    CSC 0	AREA No. _____
MEDICAL RECORD NO. _____	FAMILY ACCOUNT NO. _____	PURCHASER NO. _____
DATE RECEIVED _____	} STATUS: 0 APPROVED 0 DENIED	EFFECTIVE DATE _____

## X. INFORMATION ABOUT COVERCOLORADO

**Colorado residents** who do not qualify for Kaiser Permanente for Individuals and Families Plan may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. CoverColorado does not impose pre-existing conditions or limitations on coverage. For information about CoverColorado, please contact them directly at:

CoverColorado  
425 S. Cherry Street, Suite 160  
Glendale, CO 80246  
(303) 863-1960

