Step by Step Guide to Kaiser Enrollment Application

For members of the California Association of REALTORS®

Section B – Plan Selection

- Mark the plan you want to enroll in. All family members must enroll in one plan
- Mark your enrollment reason. If you've experienced a qualifying event, include the type and date of event
  - During the Open Enrollment every applicant should mark "Open Enrollment"
  - Outside of Open Enrollment, applicants will mark either "New C.A.R Member", "New W2 Hire", "Qualifying Event" or "Other"

Section C – Subscriber Information

- Fill in your requested effective date, C.A.R. Join Date or Hire Date (if W2 employee)
  - For Open Enrollment the Effective Date is **January 1st, 2019**
- Complete all personal information and provide your email address. We will frequently communicate with you via email so your email address is important.

Section D – Family Members

- Enter information for each family member to be covered.
- If you any family member has been a Kaiser member before, add the Medical Record Number
- Dependent children over the age of 26 are only eligible if they are disabled. Contact RealCare for information on how to certify a child's disability.
- If you need more room, add an additional page. Be sure to complete the Subscriber's name on the additional page so that we can match the dependents to the subscriber.

Section E – Arbitration Agreement & Signature (page 7)

- Read this section and **sign and date the bottom of this page**. Your application must be signed in order for us to process it.

If you have questions, please contact us at (800) 939-8088

Submit Completed Application WITH Initial Payment

- Include the initial premium payment
- If submitting application via FAX or EMAIL, add a $5.00 electronic check fee to your total premiums
- If enrolling in Automatic Premium Payment Authorization, you must include a voided check

Make your check payable to: RealCare Insurance Trust Account (R.I.T.A.)

Mail To:	Fax to:	Email to:
430 West Napa Street, Suite F Sonoma, CA 95476	(707) 939-8450	Enrollment@RealCare.biz

LUD: 10/20/18

MEDICAL APPLICATION

FOR KAISER PERMANENTE HEALTH CARE PLANS

Please print or type in black ink only. ***Fields with (*) are mandatory for enrollment.*** Retain a copy of this enrollment form and use as temporary ID after effective date

A. TO BE COMPLETED BY RealCare Insurance Marketing, Inc.
Company: California Association of REALTORS® Purchaser #: _____ (EU): _____
Purchaser Contact: **RealCare Insurance Marketing, Inc.** Phone: **(800) 939-8088**

B. PLAN SELECTION

- ☐ Bronze 60 HMO 6300/75
- ☐ Bronze 60 HDHP-HMO 6000/40% (HSA)
- ☐ Silver 70 HMO 1000/55
- ☐ Silver 70 HMO 1800/55
- ☐ Silver 70 HMO 2000/45
- ☐ Silver 70 HDHP-HMO 2500/20% (HSA)
- ☐ Gold 80 HMO 0/30
- ☐ Gold 80 HMO 500/30
- ☐ Gold 80 HRA-HMO 2250/35
- ☐ Platinum 90 HMO 0/10
- ☐ Platinum 90 HMO 0/15

Enrollment Reason - Check Only ONE:
☐ New C.A.R. Member ☐ Open Enrollment
☐ New W-2 Hire
☐ Qualifying Event: _____
Event Date: _____/_____/_____
☐ Other: _____

C. SUBSCRIBER INFORMATION

Requested Effective Date of Coverage: _____/_____/_____ C.A.R. Join Date: _____/_____/_____ Hire Date: (If W2 Employee)_____/_____/_____

Are you now or have you ever been a Kaiser Permanente member? Yes: ☐ No: ☐
If so, what is/was your Medical Record Number? _____ *CA Real Estate License #: _____
*Last Name: _____ *First Name: _____ M.I.: _____
*Date of Birth: _____ *Gender: Male: ☐ Female: ☐ Marital Status: Single: ☐ Married: ☐
*Social Security Number: _____ Email Address: _____
*Home Address: _____ City: _____ State: _____ Zip: _____
*Mailing Address (if different than home): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____

D. LIST FAMILY MEMBERS TO BE ENROLLED (Attach additional sheets if necessary)

LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed). Dependent children may be covered up to age 26 and may be married and not attending school full-time. A dependent child who has access to other employer-sponsored health coverage is not eligible under this plan.

Last Name	First Name	MI	Relationship	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Known
Spouse/Domestic Partner			☐ Spouse ☐ Domestic Partner		/ /	M F	
Dependent			☐ Child ☐ Other		/ /	M F	
Dependent			☐ Child ☐ Other		/ /	M F	
Dependent			☐ Child ☐ Other		/ /	M F	

E. Kaiser Foundation Health Plan Arbitration Agreement:

To the best of my knowledge and belief, all information on this form is correct and true.

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 *Evidence of Coverage*.

Employee/Subscriber Signature Required _____ **Date** _____

_____
Print Employer/C.A.R. Member name (if subscriber is W-2 employee)

APPLICATION CHECKLIST

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment **(even if you are selecting the Automatic Premium Payment option)**. Include premiums/fees for all applicable insurance plans (medical, dental, vision, and life insurance).

  If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application.** After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose check for your first premium payment PLUS **a voided check.** Complete the form below and return to RealCare with your initial premium check**.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088

Submit Completed Application and Initial Payment

Mail To:
430 West Napa Street, Suite F
Sonoma, CA 95476

Fax to:
(707) 939-8450

Email to:
Enrollment@RealCare.biz

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues and/or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month prior to the month of coverage. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the first of the month of coverage. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

Policyholder Information

Policyholder name: _____ Phone:_____

Social Security Number: _____ Email Address: _____

Banking Information

Name of bank or financial institution:_____

Bank Account Name: _____

☐Checking Account ☐Savings Account Account Number: _____

Bank Routing Number:_____

Authorized Signature

_____ Date:_____

Authorized Signature
(As it appears in the financial institution's records)

PLEASE ATTACH A COPY OF YOUR VOIDED CHECK AND SUBMIT WITH YOUR ENROLLMENT APPLICATION.

Note: There is a $5.00 Electronic Check Fee for payments submitted via fax or email. Please add this amount to your total premium for the initial payment.