

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, 2021**
- 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 or 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 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 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:

430 West Napa Street, Suite F
Sonoma, CA 95476

Fax to:

(707) 939-8450

Email to:

Enrollment@RealCare.biz

MEDICAL APPLICATION

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

FOR KAISER PERMANENTE HEALTH CARE PLANS

A. TO BE COMPLETED BY RealCare Insurance Marketing, Inc.

Company: California Association of REALTORS®

Purchaser Contact: **RealCare Insurance Marketing, Inc.** Phone: (800) 939-8088

Purchaser #: _____ (EU): _____

Enrollment Reason - Check Only ONE:

- New C.A.R. Member – Join Date: _____ Open Enrollment New W-2 Hire – Hire Date: _____
- Qualifying Event: _____ Event Date: _____ Other: _____

B. PLAN SELECTION

- Bronze 60 HMO 5400/60 Silver 70 HMO 2250/55 Gold 80 HMO 1000/40
- Bronze 60 HMO 6300/65 Silver 70 HMO 2600/55 Gold 80 HRA-HMO 2250/35
- Bronze 60 HDHP-HMO 7000/0% (HSA) Silver 70 HDHP-HMO 2500/20% (HSA) Platinum 90 HMO 0/10
- Silver 70 HMO 1650/55 Gold 80 HMO 0/30 Platinum 90 HMO 0/20
- Silver 70 HMO 2100/55 Gold 80 HMO 250/35

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: Don't Know:

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.

Relationship	Last Name	First Name	MI	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Known
<input type="checkbox"/> Spouse						M	
<input type="checkbox"/> Domestic Partner						F	
<input type="checkbox"/> Child						M	
<input type="checkbox"/> Other						F	
<input type="checkbox"/> Child						M	
<input type="checkbox"/> Other						F	
<input type="checkbox"/> Child						M	
<input type="checkbox"/> Other						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 can't 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 initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. 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 RealCare 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.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: _____

Phone: _____ Email Address: _____

Banking Information

Name of Bank or Financial Institution: _____

Name on Bank Account: _____

Bank Routing Number: _____ Checking Account

Account Number: _____ Savings Account

Authorized Signature

Date: _____

Signature of Authorized Signer on Above Bank Account

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

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

Note: The \$5.00 Electronic Check Fee normally charged for payments submitted via fax or email is waived for the initial payment.

Rating, Billing, Cancellation & Reinstatement Policies

General Rating Rules

Member Level Rating

In accordance with the Affordable Care Act guidelines, for C.A.R. members, both Kaiser and Anthem rate each covered family member based on the home zip code for the family, and the age of the covered individual. Note: For W2 employees, Anthem rates the employee and each family member based on the employer's zip code.

- Kaiser calculates rates on the age of each covered family member as of the policy renewal date (January 1st)
- Anthem Blue Cross calculates rates on the age of each covered family member as of the coverage effective date.
- Rates are re-calculated for all members on the policy renewal date, January 1st.
- When calculating rates for a family:
 - For children under 21, include a rate for only the three oldest children.
 - For children 21 and older, include a rate for each child separately.

Maximum Eligibility Age for Dependents: Medical, Dental and Vision Plans

The maximum age for a dependent child on the medical, dental and vision plans is age 26. Please read the *Who is Eligible* section in the *General Guidelines* document included on our website for additional details or call RealCare at 1-800-939-8088.

Kaiser Permanente Rating & Billing

Kaiser Service Areas/Eligibility

To be eligible to enroll in Kaiser a member must live or work within a Kaiser Service Area. However, once enrolled, members may continue coverage with Kaiser even if they move out of, or no longer work in a Kaiser Service Area.

According to Kaiser guidelines, applicants who live outside of a Kaiser Service Area but work in a Kaiser Service Area will use rates for Kaiser's designated "Out of Area" region ("Region 4, 8 and out of area").

Rates

- For C.A.R. Members, Kaiser rates are based on the plan selected, the member's home zip code and county, and each covered family member's age as of the 1st day of the current plan year. If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on plan renewal date, January 1st.
- For W2 employees, the rates are based on the plan selected, each family member's age as of the 1st day of the current plan year, and the employee's zip code and county. If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on plan renewal date, January 1st.
- Rating Changes during the year
 - **If a member is added** during the plan year Kaiser will use the member's age as of the 1st of the month of the current plan year to determine the rate.
 - **If a member is dropped** during the plan year, Kaiser will reduce the billed amount by the cost for the member whose coverage terminated as of the effective date of the change.
 - **If a member changes plans** as a result of a qualifying event, all members will be re-rated based on the new plan as of the effective date of the change.
- Annual Renewal Date
 - The plan renews each year on January 1st. Rate changes take effect on January 1st regardless of the member's initial effective date.

Initial Payment

All applicants are required to pay a minimum of the first month's premium with their enrollment application unless they have authorized RealCare to draft monthly automatic payments from a bank account and their application is completed in time for the automatic payment to be withdrawn for their first month of coverage. The initial premium payment may be mailed, faxed, or scanned and emailed.

Monthly Billing Cycle – Kaiser (with or without dental/vision)

Bills are generated around the 6th of each month. Premiums are due the 25th of the month prior to the coverage month. If payment is not received within 10 days of the due date, a late fee of \$15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.

Payments

Monthly payments may be made by check or Automatic Premium Payment Authorization.

Check Payments

Checks should be made **payable to RealCare Insurance Trust Account (RITA)**

- If Mailed, send to: 430 West Napa Street, Suite F, Sonoma, CA, 95476.
- If Faxed, add the \$5.00 processing fee to the total premium and fax your check to: (707) 939-8450
- If Scanned/Emailed, add the \$5.00 processing fee to the total premium and scan/email to: enrollment@realcare.biz
 - For initial premium payment only, the \$5.00 electronic check processing fee is waived.

Automatic Premium Payment Authorization (APPA)

Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the first business day of the month. If an automatic debit is dishonored, a \$25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

Cancellation of Coverage

Voluntary Termination

A subscriber may voluntarily cancel coverage for himself or covered dependents. A subscriber who wishes to terminate coverage for any covered person must submit the completed termination form to RealCare Insurance Marketing - available on our member websites, www.RealCareOnline.com or www.RealCareCAR.com. The effective date of termination will be no earlier than the first of the month following receipt of the completed form.

Involuntary Termination

RealCare may cancel coverage for:

- Failing to pay premium and applicable administrative fees before the end of the grace period
- Failing to maintain active membership in C.A.R.
- Providing false information about membership in C.A.R.
- Providing false information about eligibility
- Providing false information about a qualifying event
- Reaching maximum allowable age for a dependent child
- Failing to continue to meet eligibility requirements as a member, employee or dependent

Reinstatement

- Subject to approval from the insurance carrier, a subscriber may be allowed to reinstate his/her coverage if the subscriber submits a cashier's check or money order for all premiums, dues and administrative fees due, plus a \$25 fee for the first reinstatement and \$50 for subsequent reinstatement, payable to RealCare Insurance Trust Account, (RITA). If a reinstatement request is approved by the insurance carrier, coverage will be reinstated effective as of the cancellation date.
- If your medical coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 60 days of a qualifying event. If your life coverage is not reinstated, you may be eligible to re-enroll; however medical underwriting will be required and coverage is not guaranteed. If your dental or vision coverage is terminated for any reason, you may be eligible to re-enroll at the first Open Enrollment following a thirteen month waiting period or within 60 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your coverage is not reinstated, please contact RealCare to review your health care coverage options.

Eligibility for Re-Enrollment

Re-Enrollment is contingent on meeting all eligibility requirements.

Kaiser: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or during a Special Enrollment Period following a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

Anthem Blue Cross: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or during a Special Enrollment Period following a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Dental & Vision: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next applicable Open Enrollment following a 13 month waiting period; or within 31 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Life: If your coverage terminates and you are ineligible for reinstatement, you will not be allowed to re-enroll without submitting evidence of medical insurability. If you must re-apply, coverage is not guaranteed.

Plan Administration

Plan Administrator

The C.A.R. Insurance Plan is administered by the California Association of REALTORS® (C.A.R.) On behalf of C.A.R., RealCare Insurance Marketing, Inc., a licensed Third Party Administrator, handles all eligibility, enrollment and billing. The RealCare office is located at 430 West Napa Street, Suite F, Sonoma, CA 95476. Calls and inquires can be directed to this office at 800-939-8088. Information on plans and rates; forms, administrative policies and Explanation of Coverage documents can be found on the RealCare website, www.RealCareCAR.com.

RealCare is licensed as a third party administrator by the California Department of Insurance, license Number 0B23546.

Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.

C.A.R. Health Plan Administrative Fees

The following is a list of administrative fees charged by RealCare.

Check By Fax or Scan/Email (waived for initial premium payment)	\$ 5.00
Credit Card convenience fee	\$25.00
Late Fee (for past due payments)	\$15.00
Monthly Administration Fees:	
Accounts that include medical coverage	\$22.00
Accounts that include dental coverage and no medical coverage	\$ 5.00
Accounts that include vision and/or life insurance without medical or dental coverage	\$ 2.00
Reinstatement Fee	\$25.00
Reinstatement Fee (Second and subsequent reinstatement in a plan year)	\$50.00
Returned Check Fee	\$25.00
Returned Item Fee for Automatic Premium Payment Deduction	\$25.00

For more information visit: www.RealCareCAR.com