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**

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 5800/60
☐ Bronze 60 HDHP-HMO 6650/0% (HSA)
☐ Silver 70 HMO 1900/65
☐ Silver 70 HMO 2300/65
☐ Silver 70 HMO 2500/55
☐ Silver 70 HMO 2900/65
☐ Silver 70 HDHP-HMO 2850/25% (HSA)
☐ Gold 80 HMO 0/35
☐ Gold 80 HMO 250/35
☐ Gold 80 HMO 1000/40
☐ Gold 80 HDHP-HMO 1750/15%
☐ Gold 80 HRA-HMO 2250/35
☐ Platinum 90 HMO 0/10
☐ Platinum 90 HMO 0/20
☐ Platinum 90 HMO 250/30

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
☐ Spouse ☐ Domestic Partner						M F	
☐ Child ☐ Other						M F	
☐ Child ☐ Other						M F	
☐ 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 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** _____________

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