KAISER PERMANENTE®

Child Health Plan

This form is for self-employed applicants only.
Este formulario sólo es para solicitantes que trabajan por cuenta propia.

Profit & Loss Statement
Estado de pérdidas y ganancias

Owner/Propietario: ____________________

Type of Business/Tipo de negocio: ____________________

Address/Dirección: ____________________

City/Ciudad: ____________________ State/Estado: ________ ZIP/Código Postal: ____________

Month/Mes ______	Month/Mes ______	Month/Mes ______
Year/Año ______	Year/Año ______	Year/Año ______
Gross Income/Ingresos brutos (before taxes/antes de los impuestos): ______	Gross Income/Ingresos brutos (before taxes/antes de los impuestos): ______	Gross Income/Ingresos brutos (before taxes/antes de los impuestos): ______
Deductions/Deducciones:	Deductions/Deducciones:	Deductions/Deducciones:
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______
4. ______	4. ______	4. ______
5. ______	5. ______	5. ______
6. ______	6. ______	6. ______
Total Expenses/Gastos totales: ______	Total Expenses/Gastos totales: ______	Total Expenses/Gastos totales: ______
Net Profit/Ganancias netas: ______	Net Profit/Ganancias netas: ______	Net Profit/Ganancias netas: ______

I understand that any false information will result in the cancellation of my application/coverage in the Kaiser Permanente Child Health Plan.

Entiendo que proporcionar cualquier tipo de información falsa resultará en la cancelación de mi solicitud/cobertura con el Kaiser Permanente Child Health Plan.

Signature/Firma: ____________________ Date/Fecha: ____________

KAISER PERMANENTE®

Kaiser Permanente Child Health Plan

1. Tell us about the person applying for the child(ren). (The non-covered Subscriber who applied for the child(ren).)

☐ Mrs. ☐ Ms. ☐ Mr.

Last Name | First Name | Middle Initial

Date of Birth: ____ / ____ / ____ (month / day / year)

Gender ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Domestic Partner ☐ Widowed

Child(ren)'s Home Address (if different from mailing/billing address) (Do not use P.O. Box) Apt. No. | City | State | ZIP Code

Mailing/Billing Address | Apt. No. | City | State | ZIP Code

Daytime Telephone Number | Evening Telephone Number

Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

If you were a previous Kaiser Permanente member under a different name, what name did you use?________________

Kaiser Permanente Medical Record Number (if available) | Social Security Number (optional)

I prefer to receive materials in: ☐ English ☐ Spanish

Race (optional): ☐ African American ☐ Latino ☐ Asian/Pacific Islander ☐ Caucasian ☐ Other ________

2. How did you hear about this program?

☐ Kaiser Permanente Member Service Call Center
☐ Web Site
☐ Ad in the mail
☐ Kaiser Permanente staff
☐ Friend or relative
☐ Other________________

☐ Community Agency (Name of Agency) ________________

Name of Assistor | Please provide KP EE Number **Internal Use Only** | Telephone Number

3. **What is the total number of people living in your home that you claim as a dependent, including yourself?** ______

4. **Tell us about the child(ren) under age 19 for whom you are applying.**
   (Attach a separate sheet if additional space is needed to list child(ren).)

	Child	**Child**	**Child**	**Child**
Last Name				
First Name				
Middle Initial				
Date of Birth: *month/day/year*	/ /	/ /	/ /	/ /
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number (optional)				
Relationship to Person Applying				
Kaiser Permanente Medical Record Number (if available)				

5. **Does your child(ren) qualify for *No-Cost Medi-Cal coverage* or *Healthy Families?***

☐ Yes ☐ No If "yes," please list their names:

Name ______ Name ______

Name ______ Name ______

6. **Is your child(ren) covered by other health coverage? (for example: from an employer, Medicare, or California Children's Services [CCS]).**

☐ Yes ☐ No If "yes," please list their names and the date health coverage ends:

Name ______ Date health coverage ends ______ Name ______ Date health coverage ends ______

Name ______ Date health coverage ends ______ Name ______ Date health coverage ends ______

7. **Does an employer pay or offer to pay for some portion of your child(ren)'s health coverage?**

☐ Yes ☐ No If "yes," please list their names and the date their health coverage ends:

Name ______ Date health coverage ends ______ Name ______ Date health coverage ends ______

Name ______ Date health coverage ends ______ Name ______ Date health coverage ends ______

8. Are you under a court order to provide health coverage for any of the child(ren) you are applying for?

☐ Yes ☐ No If "yes," please list their names.

Name

Name

Name

Name

9. Employment status

☐ Full-time ☐ Part-time ☐ Unemployed
☐ Self-employed ☐ Retired ☐ Disabled

10. How often are you paid?

☐ Once a week ☐ Every two weeks
☐ Monthly ☐ Twice a month ☐ Other ______

11. What is your spouse's employment status?

☐ Full-time ☐ Part-time ☐ Unemployed
☐ Self-employed ☐ Retired ☐ Disabled

12. How often is your spouse paid?

☐ Once a week ☐ Every two weeks
☐ Monthly ☐ Twice a month ☐ Other ______

13. Total household gross income in the last calendar month

List the amount of your gross income for the last complete calendar month (for example: if you're filling this out in June, tell us what you made in May). Do not leave any space blank. If it does not apply, write "N/A" (not applicable) or "NONE."

1. Gross Income from Wages, Tips $________
2. Social Security $________
3. Support or Gifts from Family/Friends $________
4. Spousal/Child Support $________
5. Unemployment Benefits $________
6. Workers' Compensation $________
7. Disability Insurance $________
8. Veteran's Benefits $________
9. Pension/Retirement Income $________
10. Rental Income $________
11. Interest Income $________
12. Student Financial Aid $________

YOU MUST ATTACH COPIES OF YOUR MOST CURRENT PROOF OF MONTHLY INCOME FOR THE INCOME SOURCES MARKED OR YOUR APPLICATION WILL NOT BE PROCESSED (FOR EXAMPLE: PAY STUBS, AWARD LETTER, **IF SOCIAL SECURITY IS DIRECT DEPOSIT:** BANK STATEMENT, W2s FROM CURRENT EMPLOYER, **LETTER FROM EMPLOYERS ON COMPANY LETTERHEAD**).

14. Self-Employment Information

If either or both you and your spouse are self-employed, use this form to calculate income from your own businesses for the **last complete calendar month.**

Total Income This Month $________
(for example: Wages/commissions)

Less Total Expenses This Month $________
(for example: Merchandise, materials, accounting, advertising, auto, office, traveling, utilities/telephone, other)

Adjusted Gross Income for This Month $________

Please submit copies of one of the following for each business for you or your spouse:

- All pages of your last year's federal income tax return with Schedule C,
  OR
- Bank statements from personal and business accounts for the last three months,
  OR
- Profit and loss statements for the last three months

KAISER PERMANENTE®

Child Health Plan

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my 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.*

I certify that the information in this application is correct and accurate. If I provide any incorrect or incomplete information on this application or in further correspondence concerning this application, my child's coverage may be terminated.

Print Name of Applicant

Signature of Applicant

Date

Third party authorization

If you wish to give us permission to speak about your case with someone other than yourself, you must:

Complete the "Permission to share information with the following person" section below, by telling us their name and relationship (for example: spouse, employer, or assister). Sign and write today's date. If the permission is for an assister, they will sign and write today's date and complete the CAA#/EE# information.

Permission to share information with the following person:

I give permission to Kaiser Permanente Child Health Plan to give information over the telephone about the status of this application to:

Name

Relationship

Signature

Date

CAA#

EE#

PLEASE DO NOT SEND PERSONAL CHECKS, MONEY ORDERS, OR CASH WITH THIS APPLICATION.

INTERNAL USE ONLY
Family Account Number

CONTRACT DENTIST SELECTION FORM
FORMA DE CONTRATO PARA SELECCION DE DENTISTA

Please refer to the "*How to Enroll*" section on page 1
Favor de consultar la sección "Cómo Inscribirse" en la página 5

Please complete this Contract Dentist Selection Form and include your child's Kaiser medical record number, if available. You may enroll additional children by completing the information on the reverse side of this form. If you do not select a Contract Dentist Facility or the Contract Dentist Facility becomes unavailable, PMI will request the selection of another Contract Dentist Facility or assign you to a Contract Dentist Facility within your zip code.

Send completed Contract Dentist Selection form and Kaiser Child Health Plan application to:

Community Benefit Products
P.O. Box 12904
Oakland, CA 94604-9951

Favor de llenar este Formulario de Selección de Dentista Bajo Contrato e incluya el número de expediente médico de Kaiser si es disponible. Usted puede inscribir hijos addicionales, solo llene la informacion al reverso de este formulario. Si usted no selecciona una Clínica Dental Bajo Contrato o la Clínica Dental Bajo Contrato dejara de estar disponible, PMI pedirá que seleccione otra Clínica Dental Bajo Contrato o le asignará una dentro de su zona postal.

Envie el Formulario de Selección de Dentista Bajo Contrato y la applicacion Kaiser Child Health Plan a:

Community Benefit Products
P.O. Box 12904
Oakland, CA 94604-9951

Child (1) Information *Información del (1) Niño*

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)
MUY IMPORTANTE - POR FAVOR DE ESCRIBIR CLARO (Favor deje un espacio en blanco entre en medio de cada palabra)

Kaiser Medical Record Number
Numero del Expediente Medico de Kaiser

Male *Masculino* ☐ Female *Femenino* ☐

Name
Nombre
(Last / *Apellido*) (First / *Primer*) (M.I. / *Initial*)

Mailing Address
Domicilio
(Street Address / *Calle*)

(City / *Ciudad*) (State / *Estado*) (Zip Code / *Zona Postal*)

Date of Birth
Fecha de Nacimiento (Month / *Mes*) (Day / *Dia*) (Year / *Año*)

Home Phone Number
Número del telefono ( ) —

Name of Employer/Group
Nombre de Grupo Child Health Plan

E-mail Address (Optional)
Direccion de Correo Electronica

Contract Facility Name
Nombre de Clinica Dental

Contract Facility Number
Numero de Clinica Dental

To add additional Child(ren) please fill out the reverse side of this form.

Signature of Parent or Legal Guardian
Firma del Pariente o Guardián Legal ______________________

Date
Fecha ______________

Child (2) Information *Información del (2) Niño*

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)
MUY IMPORTANTE - POR FAVOR DE ESCRIBIR CLARO (Favor deje un espacio en blanco entre en medio de cada palabra)

Kaiser Medical Record Number
Numero del Expediente Medico de Kaiser

Male *Masculino* ☐ Female *Femenino* ☐

Name
Nombre
(Last / *Apellido*) (First / *Primer*) (M.I. / *Initial*)

Mailing Address
Domicilio
(Street Address - *if different than child (1) / Calle - si es diferante el niño (1)*)

(City / *Ciudad*) (State / *Estado*) (Zip Code / *Zona Postal*)

Date of Birth
Fecha de Nacimiento (Month / *Mes*) (Day / *Dia*) (Year / *Año*)

Home Phone Number
Número del telefono ( ) –

Name of Employer/Group
Nombre de Grupo Child Health Plan

E-mail Address (Optional)
Direccion de Correo Electronica

Contract Facility Name
Nombre de Clinica Dental

Contract Facility Number
Numero de Clinica Dental

Child (3) Information *Información del (3) Niño*

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)
MUY IMPORTANTE - POR FAVOR DE ESCRIBIR CLARO (Favor deje un espacio en blanco entre en medio de cada palabra)

Kaiser Medical Record Number
Numero del Expediente Medico de Kaiser

Male *Masculino* ☐ Female *Femenino* ☐

Name
Nombre
(Last / *Apellido*) (First / *Primer*) (M.I. / *Initial*)

Mailing Address
Domicilio
(Street Address - *if different than child (1) / Calle - si es diferante el niño (1)*)

(City / *Ciudad*) (State / *Estado*) (Zip Code / *Zona Postal*)

Date of Birth
Fecha de Nacimiento (Month / *Mes*) (Day / *Dia*) (Year / *Año*)

Home Phone Number
Número del telefono ( ) –

Name of Employer/Group
Nombre de Grupo Child Health Plan

E-mail Address (Optional)
Direccion de Correo Electronica

Contract Facility Name
Nombre de Clinica Dental

Contract Facility Number
Numero de Clinica Dental

Child (4) Information *Información del (4) Niño*

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)
MUY IMPORTANTE - POR FAVOR DE ESCRIBIR CLARO (Favor deje un espacio en blanco entre en medio de cada palabra)

Kaiser Medical Record Number
Numero del Expediente Medico de Kaiser

Male *Masculino* ☐ Female *Femenino* ☐

Name
Nombre
(Last / *Apellido*) (First / *Primer*) (M.I. / *Initial*)

Mailing Address
Domicilio
(Street Address - *if different than child (1) / Calle - si es diferante el niño (1)*)

(City / *Ciudad*) (State / *Estado*) (Zip Code / *Zona Postal*)

Date of Birth
Fecha de Nacimiento (Month / *Mes*) (Day / *Dia*) (Year / *Año*)

Home Phone Number
Número del telefono ( ) –

Name of Employer/Group
Nombre de Grupo Child Health Plan

E-mail Address (Optional)
Direccion de Correo Electronica

Contract Facility Name
Nombre de Clinica Dental

Contract Facility Number
Numero de Clinica Dental

Please be sure to sign and date the reverse side - *Favor de firmar y fechar al reverso*