



APPLICATION FOR SOUND HARBOR CLASSIC OR SOUND HARBOR ESSENTIAL

Please review all three pages and complete all items. This application will be returned if not completed in full. It must be signed (on the last page) by the applicant and legal spouse (if applying). **List the younger spouse as the applicant; rates may be lower (see the accompanying rate sheet for details). YOU MUST INCLUDE YOUR PAYMENT FOR THE FIRST MONTH'S PREMIUM WITH THIS APPLICATION.** Make your check or money order payable to KPS Health Plans.

Applications received by the 20th of the month will be considered for an effective date of the first of the following month unless another future date is noted here: _____

1. General Information:

Applicant's Name (last, first, middle initial):			Social Security No.:	
Street Address:		City:	State:	Zip:
Mailing Address (if different):		City:	State:	Zip:
Occupation:	Employer:	Home Telephone:	Work Telephone:	

Choose one:

New subscriber Adding dependents Transferring from a KPS or other medical plan

If transferring, please indicate plan name and ID number: _____

Effective date of previous contract: _____

Termination and/or paid through date: _____

If you are covered on any group plan or other individual plan (including Medicare or CHAMPUS) which you intend to continue, please indicate plan name and identification number: _____

2. Indicate Plan Choice:

Sound Harbor Classic \$500 Deductible Sound Harbor Essential \$1,500 Deductible
 Sound Harbor Essential \$2,500 Deductible
 Sound Harbor Essential \$5,000 Deductible

3. List name, sex, and birth date for your self and all family members to be covered. Applicant and legal spouse must not be eligible for Medicare; children must be under age 23, unmarried, and eligible as your dependents.

	LAST NAME	FIRST NAME	M.I.	SEX		BIRTH DATE		
				M	F	Mo.	Day	Yr.
Applicant								
Spouse								
Child								
Child								
Child								
Child								
Child								

Please complete the following questions so we can determine whether your previous health plan was similar. This will allow us to waive the pre-existing conditions or limitations on your new plan. (please see application instructions for more information on pre-existing conditions and a definition of creditable coverage.)

4. Did your previous policy cover prescription drugs? _____ YES _____ NO
5. Did your previous policy cover maternity? _____ YES _____ NO
6. Have you had health coverage within the past 90 days? _____ YES _____ NO

PLEASE COMPLETELY FILL OUT THE ENCLOSED HEALTH STATEMENT.

7. **Non-Smoker Certification Statement**

I have used tobacco products during the prior twelve months Yes No

My Spouse has used tobacco products during the prior twelve months Yes No

Applicant Signature

Date

Spouse Signature (if applying)

Date

If only one of you qualifies for the non-smoker rates, apply for separate contracts.

Otherwise, you will both be charged the smoker rate.

Please note: KPS reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker rates.

8. Agent Information:

FOR AGENT'S USE ONLY

AGENT VERIFICATION: Please complete the following AFTER the applicant has completed the application and health statement. To the best of my knowledge, the answers on this application and health statement are complete and accurate.

Agent/Agency Name - as licensed with KPS (please print):	Agent Signature:			Agent No.:
Mailing Address:	City:	State:	Zip:	Telephone No.:

CONDITIONS OF ENROLLMENT

PLEASE READ CAREFULLY

- I apply for enrollment with KPS Health Plans for myself and family members listed.
- I certify that all statements and answers on this application and the Health Statement are complete and true and that all rights to service are void if found false or incomplete.
- I understand and agree that discovery of any material information omitted by or for any person listed on this application or the Health Statement may result in termination of the contract retroactively.
- I understand and agree that coverage will begin on the first of the month after this application is approved by KPS Health Plans OR the first of _____ (indicate month and complete this only if you are requesting an effective date up to 90 days from date of application).
- I further understand that I must notify KPS Health Plans immediately of any change in my/our health status that may occur between now and the effective date that I have requested.
- I understand that receipt of my money (cash, check, or money order) does not constitute enrollment in the plan for which I am applying.
- I understand that the plan for which I am applying has a nine (9) month waiting period for pre-existing conditions (other than prenatal care and newborns), unless I am transferring from another KPS plan or have been continuously enrolled (a gap of no more than 63 days) in a plan with equivalent or greater benefit coverage within the nine (9) month period immediately preceding the effective date of this contract. *Please see Application Instructions for more information on pre-existing conditions and a definition of creditable coverage.*
- I understand that the plan I am applying for has a waiting period for certain listed benefits.
- I, the undersigned, have read and personally completed all of the requested information on this form. (If not, please attach a letter of explanation.)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish KPS Health Plans any and all records pertaining to medical history, services rendered, or treatment given to anyone making application, enrolled hereunder, or added hereafter for purposes of review, investigation, or evaluation of any application or a claim. This authorization extends to all aspects of treatment including testing and/or treatment for sexually transmitted diseases, substance abuse, and/or mental health. Any fees required by the provider for the release of such records will be my responsibility to pay, not KPS'. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable KPS Health Plans to process the application and claims.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

IMPORTANT: Before you sign the application, be sure that you read and understand the "Conditions" above.

Date _____ Applicant's Signature _____

Spouse's Signature (if applying) _____

Note: Parent/legal guardian must sign for dependent children

I learned about KPS through: ___ Newspaper ___ Phone Book Yellow Pages ___ Phone Book White Pages
 ___ Friend ___ Agent ___ Other

“SURE PAY” AUTOMATIC PREMIUM PAYMENT

Please complete the following form if you wish to have your monthly premium payment automatically withdrawn from your bank account. This is an optional free service for your convenience. “Sure Pay” allows KPS to arrange with your bank a transfer of sufficient funds on or about the 15th of each month for the following month’s coverage. The funds transfer will appear on your monthly bank statement, and KPS will notify you in advance if there is to be any change in the amount of your premium.

PLEASE NOTE: Payment for the first month’s premium is required with your application. After your application is approved, it may take approximately one month to complete the “Sure Pay” arrangement with your bank. If you receive any premium bills, it means the funds transfer process has not been completed and you should make the payment. The “Sure Pay” system will then take effect for the following months and you will no longer receive bills.

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AUTHORIZATION AGREEMENT FOR “SURE PAY” PREMIUM PAYMENT

I hereby authorize KPS Health Plans to initiate funds transfers from my bank account listed below and authorize my bank* to honor these transfers.

I understand that this agreement will remain in effect until KPS Health Plans has received written notice from me that it should be canceled. This notice shall be given two weeks prior to the next scheduled payment.

I have the right to stop payment of a transfer from my bank account to KPS Health Plans and must notify my bank at least two weeks before the scheduled payment date. Funds transfers are scheduled to be made on or about the 15th of each month, **prior to the month of coverage.** Any scheduled payment that is returned to KPS for funds that are not unavailable, will be charged a \$25 service fee.

NAME _____

KPS ID# _____

(Please print as shown on your bank account)

(If not issued yet, leave blank)

SIGNATURE _____

DATE _____

* As used herein, the term “bank” includes all types of financial institutions including commercial banks, savings banks, savings and loans, credit unions, etc.

PLEASE ATTACH A VOIDED CHECK FOR THE BANK ACCOUNT FROM WHICH YOU ARE AUTHORIZING SURE PAY TRANSFERS AND RETURN TO KPS HEALTH PLANS