



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
2101 East Jefferson Street, Rockville, Maryland 20852

KAISER PERMANENTE APPLICATION FOR INCAPACITATED DEPENDENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative before signing this application or card.

1. Dependent information to be completed by subscriber

Dependent	Other _____	Male	Female	
LAST NAME	FIRST NAME	MI	SUFFIX	
_____		_____	_____	
DATE OF BIRTH (MM/DD/YYYY)	MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan)	GROUP NUMBER		
_____	_____	_____		
Does dependent live with parent(s)?	Yes	No		
ADDRESS	APARTMENT NUMBER			
_____	_____			
CITY	COUNTY	STATE	ZIP CODE	
_____	_____	_____	_____	
DAY TIME PHONE (111-222-3333)	EVENING PHONE (111-222-3333)			
3333)_____	_____			
Dependent's marital status:	Single	Married	Divorced	Widowed
EMAIL ADDRESS (OPTIONAL)	_____			
_____	_____			
Is dependent entitled to other insurance?	Yes (If yes, please check applicable boxes below.)			No
	Medicaid	Medicare	Other _____	
Is dependent employed?	Yes	No		
EMPLOYER	EMPLOYER ADDRESS			
_____	_____			
APPLICANT SIGNATURE	DATE			
_____	_____			

2. Subscriber information

SUBSCRIBER LAST NAME	SUBSCRIBER FIRST NAME	MI	SUFFIX
<hr/>		<hr/>	<hr/>
MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan)	GROUP NUMBER		
<hr/>		<hr/>	<hr/>
SPOUSE LAST NAME	SPOUSE FIRST NAME	MI	SUFFIX
<hr/>		<hr/>	<hr/>
ADDRESS		APARTMENT NUMBER	
<hr/>		<hr/>	
CITY	COUNTY	STATE	ZIP CODE
<hr/>		<hr/>	<hr/>
DAY TIME PHONE (111-222-3333)	EVENING PHONE (111-222-3333)		
<hr/>		<hr/>	
EMPLOYER	EMPLOYER ADDRESS		
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Does your dependent qualify as your tax deduction? Yes No

3. To be completed by dependent's physician

In your opinion, will dependent ever be capable of self-sustaining employment? Yes No

Disability: Temporary Continuing Disability likely to improve? Yes No

Is dependent presently incapable of self-sustaining employment because of? Mental incapacity Physical handicap

Date disability occurred (MM/DD/YYYY): _____

Diagnosis of condition causing disabled status and description of limitations:

Physician's comments:

APPLICANT SIGNATURE	DATE (MM/DD/YYYY)
<hr/>	<hr/>
FACILITY	FACILITY ADDRESS
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4. To be completed by review committee

Coverage Accepted, how long? _____

Rejected, reason:

DATE REVIEWED (MM/DD/YYYY) _____

PHYSICIAN'S LAST NAME

PHYSICIAN'S FIRST NAME

MI

SUFFIX

PHYSICIAN'S SIGNATURE

AUTHORIZED SIGNATURE

DATE REVIEWED (MM/DD/YYYY)

DATE MEMBER NOTIFIED (MM/DD/YYYY) _____

TELEPHONE

LETTER

DATE FORWARDED TO MEMBERSHIP ADMINISTRATION _____