KAISER PERMANENTE®

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 (MMDDYYYY) MEDICAL RECORD # (IF ENROLLED IN KAISER PLAN) GROUP NUMBER

DOES DEPENDENT LIVE WITH PARENT(S) YES ☐ NO ☐

ADDRESS

APARTMENT NUMBER CITY COUNTY

STATE ZIP CODE (123456789) DAY TIME PHONE (1112223333) EVENING PHONE (1112223333)

DEPENDENTS MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

EMAIL ADDRESS (OPTIONAL)

IS DEPENDENT ENTITLED TO OTHER INSURANCE? ☐ YES ☐ NO If YES please check applicable boxes:

☐ 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

MEDICAL RECORD # (IF ENROLLED IN KAISER PLAN) | GROUP NUMBER

SPOUSE LAST NAME | SPOUSE FIRST NAME | MI | SUFFIX

ADDRESS

APARTMENT NUMBER | CITY | COUNTY

STATE | ZIP CODE (123456789) | DAY TIME PHONE (1112223333) | EVENING PHONE (1112223333)

EMPLOYER

EMPLOYER ADDRESS

DOES YOUR DEPENDENT QUALIFY AS YOUR TAX DEDUCTION? ☐ YES ☐ NO

3. To be completed by Dependents 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:

ATTENDING PHYSICIAN'S SIGNATURE DATE

FACILITY

FACILITY ADDRESS

4. To be completed by Review Committee:

COVERAGE: ☐ ACCEPTED, HOW LONG? _____

☐ REJECTED, REASON _____

_____

_____

_____

_____

_____

DATE REVIEWED: ☐☐☐☐☐☐☐☐ (MM/DD/YYYY)

PHYSICIAN'S NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PHYSICIAN'S SIGNATURE: _____

(MM/DD/YYYY)

AUTHORIZED SIGNATURE: _____ DATE REVIEWED: ☐☐☐☐☐☐☐☐

DATE MEMBER NOTIFIED: ☐☐☐☐☐☐☐☐ (MM/DD/YYYY) ☐ TELEPHONE ☐ LETTER

DATE FORWARDED TO MEMBERSHIP ADMINISTRATION: ☐☐☐☐☐☐☐☐ (MM/DD/YYYY)