

**MEDICAL APPLICATION**

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

**FOR KAISER PERMANENTE HEALTH CARE PLANS**

**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

**B. PLAN SELECTION**

\$5 Copay     \$30/1000     \$0/2000 HSA  
 \$15 Copay     \$30/1500     \$0/2700 HSA  
 \$20 Copay     \$40/2000     \$30/3000 HSA  
 \$30 Copay  
 \$50 Copay

Requested Effective Date of Coverage: \_\_\_\_\_  
 C.A.R. Join Date: \_\_\_\_\_

New C.A.R. Member     Open Enrollment  
 New W-2 Hire Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Qualifying Event: \_\_\_\_\_  
 Event Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Other: \_\_\_\_\_

**C. SUBSCRIBER INFORMATION**

Are you now or have you ever been a Kaiser Permanente member? Yes:  No:

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)

Last Name	First Name	MI	Role	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Know
<b>Spouse/Domestic Partner</b> <i>Maiden/Other:</i>			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		/ /	M F	
<b>Dependent</b> <i>Relationship:</i>			<input type="checkbox"/> Child <input type="checkbox"/> Student		/ /	M F	
<b>Dependent</b> <i>Relationship:</i>			<input type="checkbox"/> Child <input type="checkbox"/> Student		/ /	M F	
<b>Dependent</b> <i>Relationship:</i>			<input type="checkbox"/> Child <input type="checkbox"/> Student		/ /	M F	

**E. CERTIFICATION FOR STUDENTS OVER AGE 18:** I hereby certify that my dependent(s) is/are currently enrolled as a full time student(s) at the school(s) listed below

Name: \_\_\_\_\_ # of Units \_\_\_\_\_ Name: \_\_\_\_\_ # of Units \_\_\_\_\_  
 School Name/Address: \_\_\_\_\_ School Name/Address: \_\_\_\_\_

**F. Kaiser Foundation Health Plan Arbitration Agreement:**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, 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 (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*.

To the best of my knowledge and belief, all information on this form is correct and true.

\* Employee/Subscriber Signature Required \_\_\_\_\_ \*Date \_\_\_\_\_

## ***Kaiser Application Checklist***

- ✓ Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- ✓ Enclose initial month's premium payment (**even if you are selecting the Automatic Premium Payment option**). Include premiums for all applicable insurance plans (medical, dental, vision, and life insurance).
- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ If you are choosing the Automatic Premium Payment method, enclose a **voided check** and complete the form below and return to RealCare with your initial premium check. **The initial premium must be submitted even if you select the Automatic Premium Payment option.**
- ✓ Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- ✓ Have questions or need assistance? Call 1-800-939-8088 Ext. 202.

**Mail Applications to:  
RealCare Insurance Marketing, Inc.  
19310 Sonoma Hwy. Ste. A  
Sonoma, CA 95476**

**MONTHLY CHECKING/SAVINGS ACCOUNT  
AUTOMATIC PREMIUM PAYMENT AUTHORIZATION**

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

Automatic premium payments will be debited from my account on the date that dues/premiums are due. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium, dues and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

***Policyholder Information***

Policyholder name: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

***Banking Information***

Name of bank or financial institution: \_\_\_\_\_

Bank Account Name: \_\_\_\_\_

Checking Account     Savings Account    Account Number: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

***Authorized Signature***

Date: \_\_\_\_\_

**Authorized Signature**

*(As it appears in the financial institution's records)*

**PLEASE  
ATTACH A  
COPY OF YOUR  
VOIDED CHECK  
AND SUBMIT  
WITH YOUR  
ENROLLMENT  
APPLICATION  
AND INITIAL  
PREMIUM.**



# C.A.R. ENROLLMENT & PAYMENT INSTRUCTIONS

For Assistance, Call RealCare Insurance Marketing at (800) 939-8088

## Step 1: Calculate Rates

### Medical Plans

Medical rates are based on a Medical Rating Region for each carrier. The region is determined by the county and in some cases the zip code in which the subscriber **lives or works**. Not all zip codes in all counties appear on the Medical Rating Region page. If your zip code does not appear on the Medical Rating Region page, contact RealCare to determine if you are eligible to enroll in a Kaiser plan.

*Follow the steps below to calculate your rate:*

1. Look up your county and zip code on the Medical Rating Regions page. *(If your county is included in more than one rating region, check to find your zip code to determine what rating region to use.)*
2. Find the rate table that applies to your rating region.
3. To determine the rate, look up the subscriber's age, the plan chosen and which dependents (if any) are to be enrolled. Rates are based on the subscriber's attained age and will change effective the first day of the month following the subscriber's birthday when the attained age moves to another age category.
4. Add \$20 monthly administration fee for each month of premium submitted

### Dental/Vision/Life

The dental rates are based on the MetLife dental rating region. The rating region is determined by the county and in some cases the zip code in which the subscriber lives. The vision rates are not based on region but are determined by which (if any) dependents are enrolled. The life rates are based on the C.A.R. member's attained age and the amount of coverage purchased. **Note: You do not have to enroll the same family members in every plan. Follow the steps below to calculate your rate.**

*Follow the steps below to calculate your rate.*

1. For Dental: Look up your county on the Dental Plans rate page. Find the rate table that applies to your rating region. *(If your county is included in more than one rating region, check to find your zip code to determine what rating region to use.)* Look up the rate based on the plan chosen and whether the member wants to enroll any eligible dependents.
2. For Vision: Review the Vision Plan rate page. Find the rate based on who is enrolling on the plan.
3. For Life: Review the Life Plan rate page. Find the rate based on the C.A.R. member's attained age and the level of coverage desired. (Only available to new C.A.R. members or employees. Not available to affiliate C.A.R. members.)

## Step 2: Complete Forms

*Please note you may need to complete more than one application, depending upon the coverage you select.*

### All Applications

- ✓ Do not complete any shaded sections of the form
- ✓ **Personal Data:** List yourself and all eligible dependents you wish to enroll. Make sure to include each person's date of birth and social security number.
- ✓ **Requested Effective Date:** Write in the day, month and year. If enrolling outside of Open Enrollment, please see "General Guidelines" section "Special Enrollment Provision" for information on qualifying events and effective dates.
- ✓ **Adding Dependents after you enroll:** If you initially waive coverage for your dependents, they will not be able to enroll until the next Open Enrollment period unless they experience a qualifying event (See section "Special Enrollment Provision" for more information.) If coverage is desired for newborns, they must be added **within 30 days** of the date of their birth (their effective date of coverage will be their actual date of birth.)
- ✓ **Signature/Date:** The C.A.R. member must sign and date the form

### Kaiser Medical Application

- ✓ **Plan Selection:** Be sure to check the plan you want to enroll in.
- ✓ **Employee/Subscriber Information:** Enter your personal information, including your Kaiser Medical Records Number if you are already a Kaiser member. You will continue to use this number to obtain services.

### MetLife Dental/Life Applications

- ✓ Use this application to enroll in either of the dental plans, life insurance on a stand alone basis, or dental and life insurance together.
- ✓ **Life Insurance Beneficiary:** ONLY complete this section if you are enrolling in the life insurance program. This coverage is only available on *a guaranteed basis to new C.A.R. members and W2 employees of C.A.R. members or local C.A.R. chapters* (who enroll between their 60<sup>th</sup> and 120<sup>th</sup> day of membership; and who have not been hospitalized.) Affiliate C.A.R. members are not eligible to enroll for life insurance coverage. C.A.R. members who wish to enroll in the life insurance program outside of the new member enrollment period must contact RealCare for a separate enrollment application. Coverage for those members will not be guaranteed and will require medical history underwriting.

### MES Vision Application

- ✓ Use this application if you are enrolling in the vision plan in combination with other coverages, or on a stand alone basis.

## Step 3: Calculate Initial Payment

Use the worksheet below to calculate your initial payment:

Medical Premium	\$
Optional Dental Premium	\$
Optional Vision Premium	\$
Optional Life Premium *	\$
Monthly Administration Fee **	\$ 20.00
<b>Total Due With Applications</b>	<b>\$</b>

\* Life Insurance is guaranteed only for new members who elect coverage between their 60<sup>th</sup> and 120<sup>th</sup> day of membership and who have not been hospitalized within the 90 days prior to making application. Eligible members who wish to enroll outside of the initial eligibility date, or who have been hospitalized in the 90 days prior to making application may apply for coverage and will be medically underwritten. Coverage will not be guaranteed for these applicants.

\*\* Administration fee is lower if subscriber does not enroll in medical insurance.

## Step 3: Select A Payment Method

After the initial payment, you can either be billed monthly or pay by Automatic Premium Payment Option. Monthly invoices are generated around the 10<sup>th</sup> of the month for the following month. Premiums are due the first of the month. If you elect to pay by Automatic Premium Payment Authorization, you will need to complete the Automatic Premium Payment Authorization form and submit it with a voided check along with your initial payment. The Automatic Premium Payment will debit for all dues, premiums and fees on the due date.

## Step 4: Review & Mail Enrollment Materials & Payment

- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ Check your enrollment forms to be sure they are complete and have been signed
- ✓ Submit proof of eligibility (see Eligibility Guidelines for more information)
- ✓ Submit completed Automatic Premium Payment Authorization and voided check

**Mail Completed Application  
and Payment To:**  
**REALCARE INSURANCE MARKETING, INC.**  
19310 Sonoma Highway, Ste. A  
Sonoma, CA 95476



## KAISER PERMANENTE-METLIFE-AIG

### BILLING, CANCELLATION & REINSTATEMENT POLICIES

RealCare Insurance Marketing, Inc. Billing Department: (800) 939-8088, Ext. 201 • Fax: (707) 939-8450

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If you are enrolled in an **Anthem Blue Cross** medical plan with or without MetLife dental or life or MES vision plan, premiums are billed based on the Anthem Blue Cross-MetLife-MES Billing Cancellation and Reinstatement Policies. If you are not enrolled in an Anthem Blue Cross medical plan, refer to the **Kaiser Permanente-MetLife-MES** Billing, Cancellation and Reinstatement Policies.

#### Monthly Billing

- Bills are sent to Plan members around the 12<sup>th</sup> of each month. Premiums are due the 1<sup>st</sup> of each coverage month. If payment is not received by the 10<sup>th</sup> of the month, a late fee of \$15 will be applied. If payment is not received within 30 days of the due date, your coverage will be terminated effective the last day of the month through which premiums have been paid.
- Kaiser rates are based on the subscriber's attained age, subscriber's zip code and dependent status. If a subscriber has a birthday that moves him/her into the next age bracket, the rate increase will become effective the first of the month following the subscriber's birthday and will be reflected on that month's billing statement.
- Checks should be made payable to RealCare Insurance Trust Account (RITA) and remitted to 19310 Sonoma Highway, Suite A, Sonoma, CA 95476.

#### Automatic Premium Payment Authorization (APPA)

- Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the due date. A premium statement will be mailed each month showing the amount to be debited. If an automatic debit is dishonored, a \$25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

#### Cancellation

- Coverage may be cancelled for:
  - ✓ Failing to pay premium and applicable administrative fees before the end of the grace period.
  - ✓ Providing false information about membership in C.A.R.
  - ✓ Providing false information about eligibility.
  - ✓ Providing false information about a qualifying event.
  - ✓ Failing to maintain active membership in C.A.R.

#### Voluntary Termination

- A subscriber may voluntarily cancel coverage for himself or covered dependents. Requests to terminate coverage for any covered person must be made in writing to RealCare Insurance Marketing. It is recommended that members use the Termination Request Form available on the RealCareOnline website. The effective date of termination will be the first of the month following receipt of the written request to terminate.

#### Reinstatement/Re-Enrollment Policy

- A subscriber may reinstate his/her coverage twice in a plan year (June 1 to May 31) if the subscriber submits a cashier's check or money order for all premiums, dues and administrative fees due plus a reinstatement fee of \$25. All reinstatement payments must be received by RealCare within 45 days of the cancellation date.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your **medical or vision** coverage is not reinstated, you will be eligible to re-enroll at the next Open Enrollment or within 30 days of a qualifying event. If your **dental** coverage is terminated for any reason, you will be eligible to re-enroll at the first Open Enrollment following a three month waiting period. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

#### Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.