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). Dependent children may be covered up to age 26 and may be married and not attending school full-time. A dependent child who has access to other employer-sponsored health coverage is not eligible under this plan.

Last Name	First Name	MI	Role	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Know
Spouse/Domestic Partner *Maiden/Other:*			☐ Spouse ☐ Domestic Partner		/ /	M F	
Dependent *Relationship:*			☐ Child ☐ Student		/ /	M F	
Dependent *Relationship:*			☐ Child ☐ Student		/ /	M F	
Dependent *Relationship:*			☐ Child ☐ Student		/ /	M F	

E. 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** _____________

____
Print Employer/C.A.R. Member name (if subscriber is W-2 employee)