KAISER PERMANENTE
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.

A. TO BE COMPLETED BY REALCARE

Company: **California Association of REALTORS**

Purchaser Number _______ – Enrollment Unit Number (EU) _______

Purchaser Contact: **RealCare Insurance Marketing, Inc.**

Phone Number: **(800) 939-8088**

B. PLAN SELECTION*

❑ Plan 5 copay ❑ Plan 50 copay
❑ Plan 15 copay ❑ Plan 0/$1,500 deductible
❑ Plan 20 copay ❑ Plan 30/$1,000 deductible
❑ Plan 30 copay Plan 30/$1,500 deductible

Requested Effective Date of Coverage _______

***Enrollment Reason - Check only one:**
❑ New CAR member - New Hire
CAR Join /Hire Date: _______
❑ Open Enrollment
❑ Other: ____ Per Group

C. SUBSCRIBER/EMPLOYEE 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 # _______

Have you ever received care from Kaiser Permanente within the state of California? ❑ **Yes** ❑ **No**

Employment Status: ❑ Working ❑ Retired

Under what name: _______ Maiden/Other

____–____–____ *Social Security Number _______ *Last Name _______ *First Name ____ MI

____/____/____ *Date of Birth *Gender: ❑ M ❑ F Marital Status: ❑ Married ❑ Single _______ Email Address

_______ *Home address _______ *City ____ *State ____ *ZIP Code ____ *County

_______ *Billing Address (if different than home) _______ *City ____ *State ____ *ZIP Code ____ *County

(____) _______ Home Phone (____) _______ Business Phone (____) _______ Cell. Phone _______ Preferred Language

D. 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 Known
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	

Dependent(s') Address (if different from subscriber's): ❑ Check here if all dependents are at the address below.

Name(s)	Address	City	State	ZIP Code

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. OTHER COVERAGE INFORMATION:
Including yourself, do any of the persons listed above have other coverage? ❑ **Yes** ❑ **No**

_______ Name _______ Insurance carrier name _______ Policy number/Effective date _______ Phone number

G. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA regarding certain benefit related disputes) any dispute between myself, my heirs, 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, 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 my 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*.

X _______ ***Employee/Subscriber Signature**
X _______ ***Date**
_______ **Print Employer/C.A.R. Member name (if subscriber is W-2 employee)**

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.

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 60th and 120th 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:

Item	Amount
Medical Premium	$
Optional Dental Premium	$
Optional Vision Premium	$
Optional Life Premium *	$
Monthly Administration Fee **	$ 20.00
Total Due With Applications	**$**

* Life Insurance is guaranteed only for new members who elect coverage between their 60th and 120th 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 10th 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