



Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813

**Use a ballpoint pen, press firmly, and print legibly.**

<input type="checkbox"/> New application for membership <input type="checkbox"/> Addition of dependents <input type="checkbox"/> Renewal <input type="checkbox"/> Deletion of dependents <b>Include spouse and unmarried dependents under 19 only.</b>	Student's name:  Social Security number:      -      -
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**ABOUT YOUR FAMILY**

POS	Member ID no.	Last name	First name	MI	Former name(s)	M/F	Birth date MM/DD/YY
1		Student:					
2		Spouse:					
3		Dependents:					

I apply for health plan membership for the person(s) listed and agree that we shall abide by the Kaiser Permanente for Individuals and Families Hawai'i Pacific University Student Plan Non-Group Medical and Hospital Service Agreement, benefit schedule, rider, and contract face sheet (known as "Service Agreement"), including provisions which require that:

- 1) Except for certain situations outlined in my Service Agreement, all claims, disputes, or causes of action arising out of or related to my Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. I understand that a complete description of the arbitration provision is contained in my Service Agreement.
- 2) Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the member receives) if the care is for harm caused or alleged to be caused by a third party.
- 3) I have read the privacy information below.
- 4) I certify that I am at least 18 years of age and have the legal authority to contract for medical insurance for the person(s) listed on this enrollment form.
- 5) Members who are eligible for or entitled to Medicare are not eligible to enroll in this plan.

Student's signature	Date
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Street address	Apt.	City	State	ZIP code	Phone
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School term <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Spring and Summer	Student ID #	Student e-mail address
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<b>FOR OFFICIAL USE</b>	Amount paid	Received by	Your health insurance is effective
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### Privacy Information

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws. We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization. Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement, customer service and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our *Notice of Privacy Practices* which is on our Web site, in our medical offices, or by calling our Customer Service Center. If you have questions or concerns about our privacy practices, please contact our Customer Service Center at **432-5955** (Oahu) or **1-800-966-5955** (Neighbor Islands).



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<b>ABOUT YOUR FAMILY</b>							
POS	Member ID no.	Last name	First name	MI	Former name(s)	M/F	Birth date MM/DD/YY
1		Student:					
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<p>I apply for health plan membership for the person(s) listed and agree that we shall abide by the Kaiser Permanente for Individuals and Families Hawai'i Pacific University Student Plan Non-Group Medical and Hospital Service Agreement, benefit schedule, rider, and contract face sheet (known as "Service Agreement"), including provisions which require that:</p> <ol style="list-style-type: none"> <li>1) Except for certain situations outlined in my Service Agreement, all claims, disputes, or causes of action arising out of or related to my Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. I understand that a complete description of the arbitration provision is contained in my Service Agreement.</li> <li>2) Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the member receives) if the care is for harm caused or alleged to be caused by a third party.</li> <li>3) I have read the privacy information below.</li> <li>4) I certify that I am at least 18 years of age and have the legal authority to contract for medical insurance for the person(s) listed on this enrollment form.</li> <li>5) Members who are eligible for or entitled to Medicare are not eligible to enroll in this plan.</li> </ol>							
Student's signature				Date			
Street address		Apt.	City	State	ZIP code	Phone	
School term	<input type="checkbox"/> Fall	<input type="checkbox"/> Spring	<input type="checkbox"/> Summer	<input type="checkbox"/> Spring and Summer	Student ID #	Student e-mail address	
<b>FOR OFFICIAL USE</b>		<b>Amount paid</b>	<b>Received by</b>	<b>Your health insurance is effective</b>			

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