KAISER PERMANENTE®

Small Business
NEW GROUP APPLICATION

Fax to your Kaiser Permanente representative or your broker.

Effective date _____

1 COMPANY INFORMATION

Company name

Doing business as (DBA)	Website

Type of company ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since (mm/dd/yyyy)	Federal tax ID (EIN) number	SIC code (4 digits)

Street address (no P.O. boxes)	City	State	ZIP	County

Office phone ( ) –	Ext.	Fax ( ) –

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage if you don't have workers' compensation, unless you are exempt. I attest that the following information is correct.

☐ Yes, my company has workers' compensation.

☐ Pending

If *Yes* or *Pending*, name of carrier: _____ Policy # _____
(indicate "unknown" or "pending" as applicable)

☐ Exempt - I am not required to have workers' compensation for the following reason: _____

2A EMPLOYER ELIGIBILITY

In determining the number of employees or eligible employees, affiliated companies that are eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer and must apply as 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

2B EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Total _____ Authorized company signer's initials _____

Note: If the total number of employees noted above is 100 or less, skip the following and go to section 2C.

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year.

Total _____ Authorized company signer's initials _____

2C ELIGIBLE EMPLOYEES

Please provide the total number of **eligible employees.** Please refer to the Small Business Guidelines for information on eligible employees.

Total _____ Authorized company signer's initials _____

3 CONTINUATION COVERAGE[1]

What type of continuation coverage is your company subject to? ☐ Federal COBRA (20+ employees) ☐ Cal-COBRA (2–19 employees)

How many Federal COBRA applications will you be submitting as of the group's effective date? _____
For Cal-COBRA applications, contact our Member Service Contact Center at **800-464-4000.**

Company name (please print): _____

4 COMPANY PREMIUM CONTRIBUTION

Company contribution for employee coverage

Your contribution to employee coverage can be a percentage or a fixed dollar amount. Your minimum contribution must be at least 50% of the employee's premium for the lowest-priced Kaiser Permanente medical plan offered by you, the employer.

Percentage of the premium is based on the following **(select 1 only):**

☐ Lowest-priced Kaiser Permanente medical plan offered by the employer ☐ All Kaiser Permanente medical plans offered by the employer

Employee coverage contribution: $ _____ or _____ % of premium

Company contribution for dependent coverage

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage.[2] Dependent coverage is optional for groups with 49 or less employees. **You don't have to contribute to dependent coverage.**

Company dependent coverage: ☐ Yes ☐ No

Dependent coverage contribution: $ _____ or _____% of premium **(enter "0" if you are offering but not contributing to dependent coverage).**

5 OTHER MEDICAL INSURANCE

Does your company or affiliated company(ies) have or has it ever had group insurance directly through Kaiser Permanente? If *Yes*, please provide the customer ID, group number, and company name.

☐ Yes ☐ No Customer ID #/Group #/Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier:

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: Number of employees enrolled:

6 ERISA STATUS

Is your company subject to ERISA?[3] ☐ Yes ☐ No If you do not select an answer, we will record your status as *Yes*.

7 CONTRACT SIGNER INFORMATION

There is only 1 contract signer. This principal person is responsible for signing the group agreement, providing renewal information, and authorized to make membership or contractual changes to your account.

First name	MI	Last name		
Street address		City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –	
Email		How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail		

8 CONTRACT DELIVERY PREFERENCE

We will deliver your Kaiser Foundation Health Plan, Inc. (KFHP)/Kaiser Permanente Insurance Company (KPIC) contracts online in a PDF file at **account.kp.org** unless you indicate below that you would like your contract(s) mailed to you.

☐ I want to receive my contract(s) by mail.

Company name (please print): _____

9 BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information, but is not authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed. **If you're using a Third-Party Administrator (TPA), including a broker acting as a TPA for billing administration, please skip the following and proceed to section 10.**

☐ Check here if same as contract signer.

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only)
	☐ Email ☐ Fax ☐ Mail

10 THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The TPA contact is an external person, company, or broker that is contracted for the purpose of administering the group's billing and enrollment or solely administering your COBRA benefits. This person will have access to group information, but is not authorized to sign the group agreement or to make contractual changes to your account.

TPA company name

Will a TPA, including a broker, administer Federal COBRA? ☐ Yes ☐ No

Note: A TPA cannot administer Cal-COBRA. TPA is for Federal COBRA administration only.

First name	MI	Last name

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only)
	☐ Email ☐ Fax ☐ Mail

Company name (please print): _____

11 INTERESTED PARTY

An interested party is an individual authorized to access your group's information, such as enrollees, premium contributions, and plan selections. An interested party may also be authorized to make changes to your contract, such as adding/deleting plans, adding/deleting employees, changing waiting periods, or increasing/decreasing company premium contributions.

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only)
	☐ Email ☐ Fax ☐ Mail

ADDITIONAL INTERESTED PARTY

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only)
	☐ Email ☐ Fax ☐ Mail

12 PROPRIETOR, PARTNER, AND CORPORATE OFFICER INFORMATION

Please list all Proprietor, Partner, and Corporate Officer names below.

Name	Title
Name	Title
Name	Title
Name	Title
Name	Title
Name	Title

Company name (please print): _____

13 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by your Kaiser Permanente–appointed agent/broker after completion of this application. If you are a broker who has not registered as a firm or agent with Kaiser Permanente, please call Broker Sales at **800-789-4661, option 4.**

Notice to agent or broker:
If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

You must select Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

Agent name	License number

Office phone	Fax	Cell phone
( ) –	( ) –	( ) –

Email

Firm name	Kaiser Permanente broker firm ID

Street address	City	State	ZIP

Agent/broker signature	Date
X	

14 MEDICAL PLANS

Please select the plan(s) you would like to offer. For more information on the plans listed below, contact your sales representative or agent/broker. You're eligible to offer a choice of plans to your employees.

- Groups with 1 to 5 enrolled subscribers can offer a choice of up to 3 Kaiser Permanente plans.
- Groups with 6 or more enrolled subscribers can offer a choice of 1 or more Kaiser Permanente plans.

Bronze	☐ Bronze 60 HMO 6300/75 + Child Dental ☐ Bronze 60 HDHP HMO 4800/40% + Child Dental	☐ Bronze 60 PPO 6300/75 + Child Dental*
Silver	☐ Silver 70 HMO 1000/50 + Child Dental Alt† ☐ Silver 70 HMO 2000/45 + Child Dental	☐ Silver 70 HDHP HMO 2000/20% + Child Dental ☐ Silver 70 PPO 2000/45 + Child Dental*
Gold	☐ Gold 80 HMO 0/30 + Child Dental ☐ Gold 80 HMO 500/35 + Child Dental Alt†	☐ Gold 80 HRA HMO 2000/30 + Child Dental ☐ Gold 80 PPO 0/30 + Child Dental*
Platinum	☐ Platinum 90 HMO 0/10 + Child Dental Alt† ☐ Platinum 90 HMO 0/15 + Child Dental	☐ Platinum 90 PPO 0/15 + Child Dental*

Child Dental: We're required to include child dental benefits with your medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. PPO medical plan members receive child dental benefits as part of their medical coverage and not as a separate plan. Child dental services apply to all members under 19 years old.

*PPOs can only be offered when Kaiser Permanente is the sole carrier. Only 1 PPO plan is allowed per contract.
†Chiropractic and acupuncture benefits are included with these plans.

Groups selecting the Gold 80 HRA HMO 2000/30 plan above must fund an HRA for each enrolled employee. The allowable funding range is $250 to $600 per employee. If the group covers dependents, the allowable funding range per family is $500 to $1,200.

HDHP plans are HSA-qualified. If you have selected an HDHP or HRA medical plan above, please indicate if you would also like Kaiser Permanente to administer your HSA or HRA health payment account.

HSA administered through Kaiser Permanente? ☐ **Yes** ☐ **No** **HRA administered through Kaiser Permanente?** ☐ **Yes** ☐ **No**

If you have selected *Yes*, a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.

To help you make an informed choice, Summary of Benefits and Coverage (SBC) documents for all our plans are available at **kp.org/smallbusiness-sbc/ca**. SBCs summarize important information about our health coverage options in a standard format, so you can easily compare benefits and coverage offered by Kaiser Permanente and other carriers.

Company name (please print): _____

15 DENTAL PLANS

FAMILY DENTAL PLANS[4]

Our family dental plans cover the entire family, including adults and dependent children up to age 26. However, a family dental plan is not a substitute for the child dental coverage required by Affordable Care Act (ACA) regulations for members under age 19. Please select only 1 plan.

KPIC Fee-for-service (Premier)	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan E with Ortho **(requires at least 10 subscribers)**
KPIC PPO	☐ PPO D 1500	☐ PPO E 1000	☐ PPO E 1500	
DeltaCare HMO	☐ 10A HMO	☐ 13B HMO		

16 INFERTILITY BENEFIT

The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier. If you select this benefit, it will be added to all the HMO plans you offer and the cost will be included in the medical plan rate.

☐ Add infertility benefit

17 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.

The Copayment plans, HSA-qualified High Deductible Health Plans (HDHP), Deductible HMO plans, Deductible HMO plans with HRA, and the Chiropractic/Acupuncture plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the Preferred Provider Organization (PPO) plans as well as the Premier and PPO dental plans. The Chiropractic/Acupuncture plan is administered by American Specialty Health Plans of California, Inc.

KPIC plans are offered alongside KFHP HMO plans and are intended to provide employees of groups eligible for KFHP's HMO plans an insurance-based plan alternative.

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining health insurance coverage.

18 FOOTNOTE INFORMATION

[1] The employer retains all COBRA administrative responsibilities (such as notifying qualified beneficiaries of COBRA rights and processing COBRA elections) but delegates to Kaiser Foundation Health Plan, Inc. (Health Plan), the following clerical functions: billing Cal-COBRA members for applicable premiums (the employer authorizes Health Plan to add an administrative charge for this service), and terminating Cal-COBRA members for nonpayment of Cal-COBRA premiums or for expiration of the expected time limit that the employer specifies for Cal-COBRA coverage. If you use a Third-Party Administrator (TPA), please contact your Kaiser Permanente representative.

[2] For more information about Employer Shared Responsibility, see section 4980(H)(c)(2) of the Internal Revenue Code.

[3] ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally are not. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

[4] Dental plans are available only when purchased with a medical plan. If you choose a dental plan, all eligible subscribers and dependents must participate. A medical PPO plan member living outside California is not eligible for the DeltaCare HMO family dental plan.

Company name (please print): _____

19 SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP and KPIC, I agree that:

- Prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement.
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- The eligibility data provided by my company to Kaiser Permanente will include coverage effective dates for my company's employees in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods may not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents will be on the 1st of the month and will not exceed the waiting period established by my company.
- My company will abide by the contract provisions.

I have read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which may be included with my rate quote or, if not included, is available at **kp.org/smallbusinessguidelines/ca**.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I will comply with the 70% participation provision, as outlined in the small business guidelines.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I will be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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*.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente plans **X**	Date

*Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.