KAISER PERMANENTE®

Enrollment Provisions

As an employer interested in offering Kaiser Permanente coverage, you should be aware of the following provisions:

Eligibility

• Employees and their family dependents (spouse/domestic partners, unmarried children to age 19, and students to age 24) are eligible for coverage if they live within our Service Area. Domestic partners are eligible to enroll under this coverage.

Annual Open Enrollment

• Once a year, employees must be given the opportunity to change plans or add dependents not previously enrolled.

• Employees and/or dependents who do not enroll when first eligible must wait until the annual open enrollment period to enroll unless enrollment is due to new dependents or loss of other coverage.

Subscriber Minimum

• Your company qualifies for our small group coverage if you have had at least 2 and no more than 50 full-time (at least 30 hours per week) employees for at least 50% of the previous calendar quarter from the effective date. Eligibility is defined as those living in the Service Area as defined below.

California Enrollment Guidelines: Minimum of 1 enrolled, with at least 70% of eligible employees covered by any group health plan (i.e. through their employer or their spouse's).

Employer's Contribution and Payroll Deduction

• Your contribution must be at least 50% of the Kaiser Permanente rate for single subscribers. Any part of the cost not paid by your company must be collected from the employees through payroll deductions.

Full-Month Coverage

• Kaiser Permanente membership begins on the first day of the month following the waiting period that you specify and continues through the end of the termination month.

Our Service Area ZIP Codes

All new membership in Kaiser Permanente is limited to those individuals who reside within the ZIP codes listed below:

Northern California

The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within the following ZIP codes:

93230-32	93673	93844	94159-72	94282-91	94649	94963-66	95106	95267	95380-82	95452	95658-64	95851-53
93242	93675	93888	94175	94293-99	94659-62	94970-79	95108-42	95269	95385-87	95462	95667-74	95857
93601-02	93701-12	94002-03	94177	94301-10	94666	94998-99	95148	95290	95390-91	95465	95676-78	95860
93604	93714-18	94005	94188	94401-09	94701-10	95002	95150-61	95296-98	95397	95471-73	95680-83	95864-67
93606-07	93720-22	94010-12	94203-09	94497	94712	95008-09	95164	95304	95401-09	95476	95686-88	95873
93609	93724-29	94014-31	94211	94501-03	94720	95011	95170-73	95307	95416	95486-87	95690-98	95887
93611-14	93740-41	94035	94229-30	94506-31	94801-08	95013-15	95190-94	95313	95419	95492	95703	95894
93616	93744-45	94037-45	94232	94533	94820	95020**	95196	95316	95421	95602-05	95722	95899
93618	93747	94059-67	94234-37	94535-53	94850	95021	95201-13	95319-20	95425	95607-21	95736	95903
93623-27	93750	94070-71	94239-40	94555-66	94901	95026	95215	95323	95430-31	95623-26	95741-43	95961
93630-31	93755	94074	94243-50	94567*	94903-04	95030-33	95219-20	95326	95433	95628	95746-47	
93637-39	93759-62	94080	94252-54	94568-83	94912-15	95035-38	95227	95328-30	95436	95630	95758-59	
93643-46	93764-65	94083	94256-59	94585-92	94920	95042	95230-31	95336-37	95439	95632-35	95762-63	
93648-54	93771-80	94085-90	94261-63	94595-99	94922-31	95044	95234	95350-58	95441-42	95638-41	95765	
93656-57	93782	94096	94267-69	94601-15	94933	95046	95236-37	95360-61	95444	95645	95776	
93660	93784	94098-99	94271	94617-21	94937-42	95050-56	95240-42	95363	95446	95648	95798-99	
93662	93786	94101-47	94273-74	94623-27	94945-57	95070-71	95253	95366-68	95448	95650-52	95812-38	
93666-69	93790-94	94150-57	94277-80	94643	94960	95101-03	95258	95376-78	95450	95655	95840-43	

* The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.
** The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

Southern California

The Service Area is that portion of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare, and Ventura counties within the following ZIP codes:

90001-84	90397-98	90831-35	91131	91401-13	91752	92007-09	92152-55	92313-18	92501-09	92697-98	93022*	93287
90086-89	90401-11	90840	91175	91416	91754-56	92014	92158-79	92320-22	92513-19	92701-12	93030-35*	93301-09
90091	90501-10	90842	91182	91423	91758-73	92018-27	92182	92324-26	92521-22	92728	93040	93311-13
90093-97	90601-10	90844-48	91184-89	91426	91775-76	92029-30	92184	92329	92530-32	92735	93041-44*	93380-90
90099	90612	90853	91191	91436	91778	92033	92186-87	92333-37	92543-46	92780-82	93060-61*	93501-02
90101-03	90620-24	90888	91201-10	91470	91780	92037-40	92190-99	92339-41	92548	92799	93062-66	93504-05
90174	90630-33	91001	91214	91482	91784-86	92046	92201-03*	92345-46	92551-57	92801-08	93093	93510
90185	90637-40	91003	91221-22	91495-97	91788-93	92049	92210-11*	92350	92562-64	92811-12	93099	93518-19
90201-02	90650-52	91006-07	91224-26	91499	91795	92051-52	92220	92352	92567	92814-17	93203	93531-32
90209-13	90659-62	91009-12	91301-13	91501-08	91797-99	92054-58	92223	92354	92570-72	92821-23	93205-06	93534-36
90220-24	90665	91016-17	91316	91510	91801-04	92064-65	92230*	92357-59	92581-87	92825	93215-16	93539
90230-33	90670-71	91020-21	91319-22	91521-23	91841	92067-69	92234-36*	92369	92595-96	92831-38	93220	93543-44
90239-42	90680	91023-25	91324-31	91526	91896	92071-72	92240-41*	92371-78	92599	92840-46	93222	93550-53
90245	90701-03	91030-31	91333-35	91601-12	91899	92074-75	92252-56*	92382	92602-07	92850	93224-26	93560-61
90247-51	90706-07	91040-43	91337	91614-18	91901-03	92078-79	92258*	92385-86	92609-10	92856-57	93238	93563
90254-55	90710-17	91046	91340-46	91701-02	91908-17	92082-85	92260-64*	92391-94	92612	92859-71	93240-41	93581
90260-67	90720-21	91050-51	91350-65	91706	91921	92090-93	92268*	92397	92614-16	92877-83	93243	93584
90270	90723	91066	91367	91708-11	91931-33	92096	92270*	92399	92618-20	92885-87	93250-52	93586
90272	90731-34	91077	91371-72	91714-16	91935	92101-24	92274-78*	92401-08	92623-30	92899	93261	93590-91
90274-75	90740	91101-10	91376-77	91722-24	91941-47	92126-40	92282*	92410-15	92646-63	93001-07*	93263	93599
90277-78	90742-49	91114-18	91380-86	91729-35	91950-51	92142-43	92284-86*	92418	92672-79	93009*	93268	
90280	90801-10	91121	91388	91737	91962-63	92145	92292*	92420	92683-85	93010-12	93276	
90290-96	90813-15	91123-26	91392-96	91739-41	91976-80	92147	92305	92423-24	92688	93015-16	93280	
90301-13	90822	91129	91399	91743-50	91990	92149-50	92307-08	92427	92690-94	93020-21	93285	

* Subscribers residing in Coachella Valley (greater Palm Springs area) and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered dependent. Members will be contacted after enrollment regarding Plan Physician (Affiliated Physician) selection.

Service Area as of 3/1/2002. Please call the Member Service Call Center at 1-800-464-4000 if you have any questions.

KAISER PERMANENTE®

New Group Application

This application for Kaiser Foundation Health Plan, Inc. (Health Plan) benefits is intended for the business(es) below (attach additional sheets if necessary).

Effective date _____

Rating (circle one) **Age Banded** **Composite**

Small Business Advantage (please select and circle one plan)

	Southern California				Northern California			
Traditional Plan for Small Business	Plan 5-S	Plan 15-S	Plan 20-S	Plan 30-S	Plan 5-N	Plan 15-N	Plan 20-N	Plan 30-N
Added Choice for Small Business*	AC Plan				AC Plan			

**Jointly offered by Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company (KPIC).*

❑ Check here to select the optional Delta Dental coverage, underwritten by KPIC.
Please circle selected dental plan type:

Plan C	Plan D	Plan E	Plan E with Ortho (requires at least 25 subscribers)

(If your group selects a dental plan, each subscriber and dependent enrolling in the medical plan must also enroll in the dental plan.)

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone (_____)_____ Fax number (_____)_____ E-mail address (optional) _____
(By giving Kaiser Permanente your e-mail address, you agree to receive e-mail from us.)

Type of business _____ In business since _____

❑ Check here if you have previously had group insurance through Kaiser Permanente. (Please provide your previous Kaiser Permanente Group Number _____.)

❑ Check here if you currently have coverage through Pac Advantage, formerly known as the Health Insurance Plan of California (HIPC).

Principal Owners/Corporate Officers

1. _____
Name Title Social Security Number

2. _____
Name Title Social Security Number

■ Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under Health Plan.

■ How long must a new hire be employed before being offered health care benefits for **the first of the month effective date** following the waiting period? (check one) ❑ 30 days ❑ 60 days ❑ 90 days ❑ 6 mos. ❑ 1 yr. ❑ Date of hire
(Employee will be effective on the first of the month following this waiting period.)

■ Billing statements to be mailed to (person/title) ❑ Mr. ❑ Ms. _____

Address _____ City _____ State _____ ZIP _____

■ Contract to be mailed to (person/title) ❑ Mr. ❑ Ms. _____

Address _____ City _____ State _____ ZIP _____

Please complete, sign, and date below.

I authorize the following individual to act as Broker of Record for Kaiser Foundation Health Plan, Inc.

Broker name _____

Firm name _____

Broker address _____

City _____ State _____ ZIP _____

Phone (_____)_____ Fax number (_____) _____

Cal. L&D Lic. number _____ Expiration date _____

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc., **I agree that my company will contribute_____% of the rate for each employee for plan _____ ,** that our prepaid monthly dues will be submitted by the 30th of each month, prior to the month of coverage, and that my company will abide by the contract provisions. Except for Small Claims Court cases and claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members, any dispute between Members, their heirs, or 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 this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this Agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage*.

Employer Signature _____ **Title** _____ **Date** _____

Note: Submission of this application does not guarantee that coverage will be offered. Kaiser Foundation Health Plan, Inc. reserves the right to accept or decline any application.

KAISER PERMANENTE®

Health Questionnaire

Please complete this section ONLY if your group has between 16 – 50 enrolling employees:

Groups with 15 or fewer enrolling employees are not required to complete this section.

Please answer the following questions to the best of your knowledge for **enrolling employees and dependents only.** All questions must be answered to establish a final rate for your group. Incomplete information may affect your group's rate or delay the enrollment of your group.

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone (_____)_____ Fax number (_____)_____

Principal Owners/Corporate Officers

1. _____
   Name Title Social Security Number
2. _____
   Name Title Social Security Number

1.	How many employees/dependents are currently pregnant?	❑ _____ ❑ **None**
2.	How many employees/dependents have been advised to have surgery in the last six months or anticipate hospitalization for any other reason?	❑ _____ ❑ **None**
3.	How many employees/dependents have been treated for a serious illness (physical or mental) and/or had more than $5,000 of medical expenses or been hospitalized in the past 12 months?	❑ _____ ❑ **None**
4.	How many employees are not actively performing their duties full-time due to a disabling illness or injury?	❑ _____ ❑ **None**
5.	How many employees are currently confined to a hospital or treatment facility?	❑ _____ ❑ **None**

I certify that, to the best of my knowledge, the above information is true and complete. Any information provided will not result in a denial of coverage. The information will only be used for rating purposes and not for any other purpose.

Employer Signature _____ **Title** _____ **Date** _____