

Please type or print clearly using black ink.

Effective date: \_\_\_\_\_

**1 Company Information**

Company name		Federal tax ID number	
Doing business as (DBA)		Website	
Street address (no P.O. boxes)			
City		State	ZIP
Phone ( ) -	Fax ( ) -	Email	
Type of company: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company (LLC)		In business since: ____/____/____	SIC code: _____
<input type="checkbox"/> Other _____			
Total number of employees (including owners, partners, and corporate officers): _____ <b>Note:</b> Include in your count any employees, owners, partners, and corporate officers of affiliated companies that are eligible to file a combined return.		Total number of employees eligible for health coverage: _____	

**2 Company Premium Contribution**

The contribution can be a percentage or a fixed dollar amount. Minimum contribution must be at least 50 percent of the premium for a single subscriber under age 30 for the lowest-priced plan offered by the employer.

<b>Company contribution for employees:</b> \$ _____ or _____ % of the premium	<b>Company contribution for dependents:</b> \$ _____ or _____ % of the premium
Percentage of the premium is based on the following (check one): <input type="checkbox"/> medical plan the employee selects <input type="checkbox"/> rate for the employee's age band and family tier in the lowest-priced medical plan offered <input type="checkbox"/> rate for a single employee under age 30 in the lowest-priced medical plan offered	

**3 Eligible Employees**

 Coverage will be offered to employees working (check one):  
 20 hours or more per week     30 hours or more per week

**4 Waiting Period**

 Benefits are effective the first of the month following (check one):  
 Date of hire     30 days     60 days     90 days     180 days

**5 Other Medical Insurance Coverage**

Does your company have or has it ever had group insurance through Kaiser Permanente?  
 Yes     No    Customer ID #/Group #: \_\_\_\_\_

Does your company currently have active group health insurance?  
 Yes     No    Name of carrier: \_\_\_\_\_    Number of employees enrolled: \_\_\_\_\_

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?  
 Yes     No    Name of carrier: \_\_\_\_\_

**6 Continuation Coverage<sup>1</sup>**

What type of continuation coverage is your company subject to? <input type="checkbox"/> Federal COBRA (20+ employees) <input type="checkbox"/> Cal-COBRA (2-19 employees)	How many COBRA or Cal-COBRA applications will you be submitting as of the group's effective date? _____
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**7 Workers' Compensation Coverage**

 Do you have workers' compensation coverage?     Yes     No     Pending  
 Name of carrier: \_\_\_\_\_

**8 ERISA Status**

 Is your company subject to ERISA?<sup>2</sup>     Yes     No  
 Note: If you do not select an answer, we will record your status as Yes.

Company name: \_\_\_\_\_

<b>9 Contract Signer Information</b>				
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First name	MI	Last name
Address				
City			State	ZIP
Office phone ( ) -		Ext.	Fax ( ) -	Cell phone ( ) -
Contact preference (check one): <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail			Email	
<b>10 Contract Delivery Preference</b>				
We will deliver your Kaiser Foundation Health Plan (KFHP)/Kaiser Permanente Insurance Company (KPIC) contract(s) on our website unless you indicate below that you would like your contract(s) delivered by mail:				
<input type="checkbox"/> I want to receive my KFHP contracts by mail on a CD-ROM. (If you also have a KPIC health insurance contract, you will also receive your KPIC contracts by mail in paper format.)				
<input type="checkbox"/> I want to receive my KFHP contracts by mail in paper format. (If you also have a KPIC health insurance contract, you will also receive your KPIC contracts by mail in paper format.)				
<b>11 Billing Contact Information</b>				
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First name	MI	Last name
<input type="checkbox"/> Check here if this person is authorized to make changes to your contract.				
Address				
City			State	ZIP
Office phone ( ) -		Ext.	Fax ( ) -	Cell phone ( ) -
Contact preference (check one): <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail			Email	

Company name: \_\_\_\_\_

**12 Interested Party**

 (An *interested party* is an individual authorized to access private information about your group account.)

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First name	MI	Last name
<input type="checkbox"/> Check here if this person is also authorized to make changes to your contract.				
Address				
City			State	ZIP
Office phone ( ) - _____	Ext.	Fax ( ) - _____	Cell phone ( ) - _____	
Contact preference (check one): <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail		Email		

**Interested Party**

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First name	MI	Last name
<input type="checkbox"/> Check here if this person is also authorized to make changes to your contract.				
Address				
City			State	ZIP
Office phone ( ) - _____	Ext.	Fax ( ) - _____	Cell phone ( ) - _____	
Contact preference (check one): <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail		Email		

**13 Authorized Agent/Broker of Record for Kaiser Foundation Health Plan, Inc.**

(Complete only if you have a broker.)

Agent name			License number	
Office phone ( ) - _____	Ext.	Fax ( ) - _____	Cell phone ( ) - _____	
Email				
Firm name		Kaiser Permanente broker firm ID		
Address				
City			State	ZIP

**If your broker has not registered as a firm or agent with Kaiser Permanente, please advise your broker to call  
Broker Compensation Services at 1-800-440-2323.**

**Company name:** \_\_\_\_\_

**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.

Are you selecting two or more medical plans?<sup>3</sup>     Yes     No

<b>Copayment HMO plans</b>	<input type="checkbox"/> \$5 plan	<input type="checkbox"/> \$15 plan	<input type="checkbox"/> \$20 plan	<input type="checkbox"/> \$30 plan	<input type="checkbox"/> \$50 plan
<b>HSA-qualified deductible HMO plans</b>	<input type="checkbox"/> \$0/\$2,000 plan with HSA	<input type="checkbox"/> \$0/\$2,700 plan with HSA	<input type="checkbox"/> \$30/\$3,000 plan with HSA		
<b>Deductible HMO plans</b>	<input type="checkbox"/> \$30/\$1,000 plan	<input type="checkbox"/> \$30/\$1,500 plan	<input type="checkbox"/> \$40/\$2,000 plan	<input type="checkbox"/> \$40/\$3,000 plan	
<b>Deductible HMO plans with HRA</b>	<input type="checkbox"/> \$30/\$1,500 plan with HRA	<input type="checkbox"/> \$30/\$2,500 plan with HRA			
<b>Point-of-service (POS) plans</b>	<input type="checkbox"/> POS + GIFT plan <sup>4</sup>		<input type="checkbox"/> \$35 POS plan		
<b>Preferred provider organization (PPO) plans</b>	<input type="checkbox"/> \$40/\$1,000 plan	<input type="checkbox"/> \$40/\$2,500 plan with HSA			

**15 Dental Plans<sup>5</sup>**

Please select no more than one plan.

<b>Delta Dental Premier</b>	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan E	<input type="checkbox"/> Plan E with Ortho (requires at least 10 subscribers)
<b>Delta Dental PPO</b>	<input type="checkbox"/> PPO D 1500	<input type="checkbox"/> PPO E 1000	<input type="checkbox"/> PPO E 1500	
<b>Dental Care HMO</b>	<input type="checkbox"/> 13B HMO	<input type="checkbox"/> 10A HMO		

**16 Chiropractic/Acupuncture Plans<sup>5</sup>**

Please select the plan you would like to offer.<sup>6</sup>

- Chiropractic/Acupuncture plan
- Chiropractic/Acupuncture for the \$40/\$1,000 PPO plan only

<sup>1</sup>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.

<sup>2</sup>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 adviser before responding.

<sup>3</sup>You're eligible to offer a choice of plans to your employees if you have three or more enrolled subscribers.

- **roups with three to five enrolled subscribers can offer a choice of one or two Kaiser Permanente plans.**
- **roups with six or more enrolled subscribers can offer a choice of one or more Kaiser Permanente plans.**

<sup>4</sup>GIFT (gamete intrafallopian transfer) is an infertility treatment that involves removal, preparation, and reimplantation of ovum.

<sup>5</sup>Dental and chiropractic/acupuncture plans are available only when purchased with a medical plan. If you choose a dental and/or chiropractic/acupuncture plan, all subscribers and dependents must participate, except for out-of-state employees, who are not eligible.

<sup>6</sup>Chiropractic/acupuncture benefits cannot be combined with any HSA-qualified deductible HMO plan or the PPO with HSA plan.

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plans are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plans and the out-of-network portion of the POS plans as well as the Delta Dental of California dental plans. The chiropractic/acupuncture plan is administered by American Specialty Health Plans of California, Inc. The PPO chiropractic/acupuncture plan is administered by Private Healthcare Systems.

Company name: \_\_\_\_\_

**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 an annual 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.

**18 Authorized 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 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](http://kp.org/smallbusinessguidelines/ca).

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I have misrepresented or omitted any material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

**Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement\***

**Notice is given that, and as more fully set forth in the arbitration provision in the applicable *Evidence of Coverage (EOC)*, disputes between Members, their heirs, relatives, or associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), and 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 or coverage by KPIC, 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 and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members give up their right to a court or jury trial and accept the use of binding arbitration as specified in the applicable *EOC* except that the following types of claims are not subject to binding arbitration:**

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and **Medicare Cost Members**
- If coverage is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulations (29 CFR 2560.503-1), the claim is about an “adverse benefit determination” as defined in that regulation. Note: Claims about “adverse benefit determinations” are excluded from this binding **arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c))(4) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice.**

\*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 and 3 of the Point of Service (POS) plans, 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) plans, and 3) the KPIC Dental plans.

<b>Name</b> (please print)	<b>Title</b>
Signature <b>X</b>	<b>Date</b>