

Email application to your Kaiser Permanente representative or your broker.

Effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

## 1 COMPANY INFORMATION

Company name _____					
Doing business as B _____				e sie _____	
Type of company: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company <input type="checkbox"/> Other _____					
Business since mm/yyyy ____/____/____		Fiscal year number _____		Sole 4 digit _____	
Physical address no P.O. box _____		City _____		State _____	County _____
Phone _____		Fax _____			

I am hereby certifying that the information provided on this application is true and correct to the best of my knowledge and belief. I understand that providing false information is a violation of the law and may result in the denial of my application and/or legal action.

☐ Yes or *Pending* name of carrier \_\_\_\_\_ Policy \_\_\_\_\_  
in the event of a loss or injury as a liability

☐ I am from the United States or I am applying for the following reason: \_\_\_\_\_

## 2A EMPLOYER ELIGIBILITY

In determining if you are eligible to enroll your employees, we will consider the following factors:

1. Are you a small business? (20 or fewer employees, including full-time, part-time, and seasonal employees)

2. Are you a family-owned business? (less than 50% owned by a family)

3. Are you a non-profit organization?

4. Are you a government agency?

5. Are you a religious organization?

6. Are you a charitable organization?

7. Are you a business that is not for profit?

8. Are you a business that is not a partnership?

9. Are you a business that is not a sole proprietorship?

10. Are you a business that is not a limited liability company?

11. Are you a business that is not a partnership?

12. Are you a business that is not a sole proprietorship?

13. Are you a business that is not a limited liability company?

14. Are you a business that is not a partnership?

15. Are you a business that is not a sole proprietorship?

16. Are you a business that is not a limited liability company?

17. Are you a business that is not a partnership?

18. Are you a business that is not a sole proprietorship?

19. Are you a business that is not a limited liability company?

20. Are you a business that is not a partnership?

## 2B EMPLOYEE COUNT

Please provide the total number of full-time and part-time employees for the year ending 12/31/\_\_\_\_.

Full-time employees: \_\_\_\_\_

Part-time employees: \_\_\_\_\_

Seasonal employees: \_\_\_\_\_

Temporary employees: \_\_\_\_\_

Contract employees: \_\_\_\_\_

Other employees: \_\_\_\_\_

Total employees: \_\_\_\_\_

If your total number of employees is more than 100, please provide the following information:

1. How many full-time employees? \_\_\_\_\_

2. How many part-time employees? \_\_\_\_\_

3. How many seasonal employees? \_\_\_\_\_

4. How many temporary employees? \_\_\_\_\_

5. How many contract employees? \_\_\_\_\_

6. How many other employees? \_\_\_\_\_

Total employees: \_\_\_\_\_

## 2C ELIGIBLE EMPLOYEES

Please provide the total number of eligible employees for the year ending 12/31/\_\_\_\_.

Eligible employees: \_\_\_\_\_

## 3 CONTINUATION COVERAGE<sup>1</sup>

Are you offering continuation coverage to your employees? ☐ Yes ☐ No

If yes, please provide the following information:

1. How many employees are eligible for continuation coverage? \_\_\_\_\_

2. How many employees are currently receiving continuation coverage? \_\_\_\_\_

3. How many employees are currently receiving continuation coverage for a period of 180 days or more? \_\_\_\_\_

4. How many employees are currently receiving continuation coverage for a period of 180 days or more and are currently receiving continuation coverage for a period of 180 days or more? \_\_\_\_\_

5. How many employees are currently receiving continuation coverage for a period of 180 days or more and are currently receiving continuation coverage for a period of 180 days or more? \_\_\_\_\_

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19. How many employees are currently receiving continuation coverage for a period of 180 days or more and are currently receiving continuation coverage for a period of 180 days or more? \_\_\_\_\_

20. How many employees are currently receiving continuation coverage for a period of 180 days or more and are currently receiving continuation coverage for a period of 180 days or more? \_\_\_\_\_

Company name (please print): \_\_\_\_\_

## 4 COMPANY PREMIUM CONTRIBUTION

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Company name (please print): \_\_\_\_\_

## 9 BILLING CONTACT INFORMATION

The billing contact is the person in your community who manages a member's access to the person who provides group information. This person is also the person who signs the group agreement or contract on behalf of the group. Only one billing contact is allowed. If you are using a third-party administrator (TPA) for billing a group, please indicate the following information.

☐ The billing contact is the same as the group member.

First name	Last name
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☐ The billing contact is also the person who signs the group agreement or contract on behalf of the group.

Street address	City	State	Zip
Office phone	Area	Cell phone	
Email	How would you like to be contacted? <input type="checkbox"/> mail <input type="checkbox"/> fax <input type="checkbox"/> email		

## 10 THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The TPA is an external person or organization that provides services for the group. The TPA is responsible for billing the group and enrolling members. The TPA is also the person who signs the group agreement or contract on behalf of the group.

TPA name

Is the TPA a third-party administrator (TPA)? ☐ Yes ☐ No ☐ The TPA is the same as the group member.

Is the TPA a third-party administrator (TPA)? ☐ Yes ☐ No ☐ The TPA is the same as the group member.

First name	Last name		
Street address	City	State	Zip
Office phone	Area	Cell phone	
Email	How would you like to be contacted? <input type="checkbox"/> mail <input type="checkbox"/> fax <input type="checkbox"/> email		

Company name (please print): \_\_\_\_\_

## 11 INTERESTED PARTY CONTACT INFORMATION

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## 12 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

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Company name (please print): \_\_\_\_\_

### 13 MEDICAL PLANS

Please select the plan(s) you like to offer or more information on the plan(s) is located on your sales representative's agenda or on the Kaiser Permanente website. If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

Plan	<input type="checkbox"/> Plan 0010 - Individual	<input type="checkbox"/> Plan 0015 - Individual
	<input type="checkbox"/> Plan 0015 - Individual	
Cost	<input type="checkbox"/> Cost 025025 - Individual	<input type="checkbox"/> Cost 00PP 25025 - Individual
	<input type="checkbox"/> Cost 050030 - Individual	
	<input type="checkbox"/> Cost 0225035 - Individual	
Salary	<input type="checkbox"/> Salary 70165055 - Individual	<input type="checkbox"/> Salary 70PP 225050 - Individual
	<input type="checkbox"/> Salary 7010055 - Individual	
	<input type="checkbox"/> Salary 70225050 - Individual	
	<input type="checkbox"/> Salary 70P 250020 - Individual	
Bronze	<input type="checkbox"/> Bronze 60630065 - Individual	<input type="checkbox"/> Bronze 60PP 630065 - Individual
	<input type="checkbox"/> Bronze 60P 6000 - Individual	

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

### 14 DENTAL PLANS

Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan
Cost	<input type="checkbox"/> Cost 1500	<input type="checkbox"/> Cost 1000	<input type="checkbox"/> Cost 1500	
Salary	<input type="checkbox"/> Salary 10	<input type="checkbox"/> Salary 13B		

### 15 INFERTILITY BENEFIT

If you are offering more than one plan, please check the appropriate boxes below. If you are offering only one plan, please check the appropriate box below.

☐ Infertility benefit

Company name (please print): \_\_\_\_\_

## 16 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. Coverage will be provided only if the applicant is an eligible Kaiser Permanente member. The applicant must be a resident of California and must be a member of Kaiser Permanente. The applicant must be a member of Kaiser Permanente for at least 90 days before the date of application. The applicant must be a member of Kaiser Permanente for at least 90 days before the date of application.

The group may use the information to determine if the applicant is eligible for coverage. The group may use the information to determine if the applicant is eligible for coverage.

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## 17 FOOTNOTE INFORMATION

<sup>1</sup> The member must be a resident of California and must be a member of Kaiser Permanente for at least 90 days before the date of application. The member must be a member of Kaiser Permanente for at least 90 days before the date of application.

<sup>2</sup> For more information, see the Kaiser Permanente website at [www.kaiserpermanente.org](http://www.kaiserpermanente.org).

<sup>3</sup> This is a general statement and does not constitute an offer of insurance. The group may use the information to determine if the applicant is eligible for coverage. The group may use the information to determine if the applicant is eligible for coverage.

<sup>4</sup> The applicant must be a resident of California and must be a member of Kaiser Permanente for at least 90 days before the date of application. The applicant must be a member of Kaiser Permanente for at least 90 days before the date of application.

Company name (please print): \_\_\_\_\_

## 18 SIGNATURE

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