KAISER PERMANENTE®

California Small Group
EMPLOYER APPLICATION

Email application to your Kaiser Permanente representative or your broker.

Requested effective date _____/_____/_____

1 ABOUT BUSINESS

Legal business name (as stated on your local business license, quarterly wage and tax report, corporate or partnership documents)	Doing business as (DBA)

Physical street address **(no P.O. boxes)**	City	State	ZIP	County

Phone ( ) –	Fax ( ) –

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

In business since (mm/dd/yyyy)	Federal tax ID (EIN) number	NAICS code (6 digit)*	Website
/ /			

*You can easily find your NAICS code on **https://www.naics.com/search/**.

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're 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 from providing workers' compensation for the following reason: _____

2 OTHER MEDICAL COVERAGE

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

☐ Yes ☐ No Group ID: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal date: / /

Will you be offering a fully insured, age-rated, ACA-compliant small group metal or grandfathered (nonmetal) health plan, alongside Kaiser Permanente, to your employees?

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

3A 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

Business name (please print): _____

3B 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 fewer, skip the following and go to section 3C.

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 _____

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible employees.** Total _____ Authorized company signer's initials _____

Please provide the total number of **enrolling employees.** Total _____ Authorized company signer's initials _____

Hours per week employees must work to be eligible for coverage: ☐ 20–29 hours ☐ 30+ hours

Are you offering dependent coverage?[1] ☐ Yes ☐ No

4 CONTINUATION COVERAGE[2]

How many employees did you employ for at least 50% of the workdays of the preceding calendar year (January to December)?

☐ 2–19 employees (Group is subject to Cal-COBRA)

☐ 20+ employees (Group is subject to Federal COBRA)

Are you submitting COBRA applications? ☐ Yes ☐ No

For Cal-COBRA applications, contact our Member Service Contact Center at **800-464-4000.**

5 ERISA STATUS

Is your company subject to ERISA?[3] ☐ Yes ☐ No If you don't select an answer, we'll record your status as *Yes*.

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage or a fixed dollar amount. **Your minimum contribution must be at least 50% of the "employee only" monthly 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 plan offered ☐ All plans offered ☐ Specific plan offered: _____

Employer contribution (50%–100%): _____ % per employee _____ % per dependent **(optional)**

Employer contribution (fixed $): $ _____ per employee $ _____ per dependent **(optional)**

[1]If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980H(c)(2) of the Internal Revenue Code.

[2]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.

[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 aren't. 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.

Business name (please print): _____

7 CONTRACT AND RENEWAL DELIVERY PREFERENCE

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

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

8 CONTRACT SIGNER INFORMATION

There's 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	Title

Mailing address	City	State	ZIP

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

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

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. 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.

Mailing address	City	State	ZIP

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

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

10 THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The **TPA** is an external person, company, or broker that's contracted for the purpose of administering the group's billing and enrollment or solely administering your **Federal COBRA** benefits. This person will have access to group information.

TPA company name

Will a TPA, including a broker, administer Federal COBRA? ☐ Yes ☐ No ☐ Check here if COBRA statement will be sent to group's billing address.

Note: A TPA can't administer Cal-COBRA. TPA is for Federal COBRA administration only.

First name	MI	Last name

Mailing address	City	State	ZIP

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

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

11 INTERESTED PARTY CONTACT INFORMATION

An **interested party** is an individual within your organization authorized to discuss and receive group specific information. This individual would be someone other than a broker. An authorized agent/broker is to complete section 16.

First name	MI	Last name

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

Mailing address	City	State	ZIP

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

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

ADDITIONAL INTERESTED PARTY

First name	MI	Last name

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

Mailing address	City	State	ZIP

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

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

12 MEDICAL PLANS

Please select the plan(s) you'd 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 4 HMO Kaiser Permanente plans, plus 1 PPO plan for a maximum of 5 plans.
- Groups with 6 or more enrolled subscribers can offer a choice of 1 or more HMO Kaiser Permanente plans, plus 1 PPO plan.
- PPOs can only be offered when Kaiser Permanente is the sole carrier. Only 1 PPO plan is allowed per contract.

Platinum	☐ Platinum 90 HMO 0/10 + Child Dental Alt† ☐ Platinum 90 HMO 0/20 + Child Dental	☐ Platinum 90 PPO 0/15 + Child Dental
Gold	☐ Gold 80 HMO 0/30 + Child Dental Alt† ☐ Gold 80 HMO 250/35 + Child Dental ☐ Gold 80 HMO 1000/40 + Child Dental Alt† ☐ Gold 80 HDHP HMO 1600/15% + Child Dental Alt ☐ Gold 80 HRA HMO 2250/35 + Child Dental	☐ Gold 80 PPO 350/25 + Child Dental
Silver	☐ Silver 70 HMO 1650/55 + Child Dental Alt† ☐ Silver 70 HMO 2100/55 + Child Dental Alt† ☐ Silver 70 HMO 2250/55 + Child Dental ☐ Silver 70 HMO 2600/55 + Child Dental Alt† ☐ Silver 70 HDHP HMO 2500/20% + Child Dental	☐ Silver 70 PPO 2250/55 + Child Dental
Bronze	☐ Bronze 60 HMO 5400/60 + Child Dental Alt† ☐ Bronze 60 HMO 6300/65 + Child Dental ☐ Bronze 60 HDHP HMO 7000/0 + Child Dental	☐ Bronze 60 PPO 6300/65 + 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.

†Chiropractic and acupuncture benefits are included with these plans.

Groups selecting the Gold 80 HRA HMO 2250/35 plan above must fund an HRA for each enrolled employee. The allowable funding range is $100 to $400 per employee. If the group covers dependents, the allowable funding range per family is $200 to $800.

HDHP plans are HSA-qualified. If you've selected an HDHP or HRA medical plan above, please indicate if you'd also like Kaiser Permanente to administer your HSA or HRA health payment account. **If you select *Yes*, a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.**

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

13 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

14 DENTAL PLANS

SUPPLEMENTAL FAMILY DENTAL PLANS*

Our supplemental family dental plans cover the entire family, including adults and dependent children up to age 26. However, a supplemental family dental plan isn't a substitute for the child dental coverage required by Affordable Care Act (ACA) regulations for members under age 19. **Please select only 1 plan.** If you select this benefit, all enrolled subscribers will be enrolled in dental.

KPIC Fee-for-Service (Premier)	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan E with Ortho **(requires at least 10 subscribers)**	
KPIC PPO	☐ PPO AG 1500	☐ PPO AH 2000	☐ PPO D 1500	☐ PPO E 1000	☐ PPO E 1500
DeltaCare HMO	☐ 10A HMO	☐ 13B HMO			

*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 isn't eligible for the DeltaCare HMO family dental plan.

Business name (please print): _____

15 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 copay HMO plans, HSA-qualified high deductible health plans, deductible HMO plans, and the deductible HMO plans with HRA 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 benefit 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 coverage/health insurance coverage.

16 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by your Kaiser Permanente–appointed agent/broker after completion of this application. Your broker will have the same access to your account as an interested party with the exception that a broker can't sign this Employer Application. If you're a broker who hasn't registered as a firm or agent with Kaiser Permanente, please call Broker Sales at **800-789-4661.** If any information has changed, please call Broker Compensation at **800-440-2323.**

Notice to agent or broker: If you've 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

Primary (authorized agent/broker)	
Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID
Agent/broker signature **X**	Date
Secondary (only if adding another firm; doesn't apply to a second agent/broker at the same firm)	
Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID

Business name (please print): _____

17 AGREEMENT AND 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 that correctly account for eligibility in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods 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 won't 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 have a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) and I will comply with the health plan's participation requirement.

I attest that my company isn't participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage.

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'll 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)	Company title (please print)
Signature required for all Kaiser Permanente Plans **X**	Date

**Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages aren't subject to binding arbitration: 1) the Participating Provider tier and the Non-Participating Provider tier of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*