KAISER PERMANENTE®

California Small Group

BROKER OF RECORD AUTHORIZATION

(Existing Group)

IMPORTANT INFORMATION

- Completing this form will prompt a broker of record change which will terminate any existing broker relationship and replace them with the broker selected below.
- This form needs to be dated the 1st of the month and received within the first 5 business days of the month to be effective on the 1st of the current month. If received after the 5th business day of the month, BOR relationships can be effective on the day of receipt, with the Payee effective the 1st day of the following month. If this form is dated after the 1st of the current month, BOR relationships can be effective on the day of receipt, with payee effective the 1st day of the following month.
- Only fully appointed Kaiser Permanente agents/brokers are entitled to receive commissions in conjunction with the placement, installation and/or servicing of our insurance contract/agreement.
- Electronic signature forms will be routed for automatic processing. Any other versions of this form, must be emailed to **CA.KP.EBS@kp.org**. If you have any questions, call Employer & Broker Services at **855-327-0507** or your broker.

1 COMPANY INFORMATION

Company name	Group number
Contact name	Contact title
Contact address	Contact phone number ( ) -
Contact email	

2 AUTHORIZED CONTRACT SIGNER INFORMATION (if different from above)

Contract signer name	Contract signer phone number ( ) -
Contract signer email	

3 AGENT/BROKER INFORMATION

Effective date of new agent/broker

Agent/Broker name		CA license #	
Contact email		Contact phone number ( ) -	
Firm name		Kaiser Permanente broker firm ID	
Firm address	City	State	ZIP code

4 AGENT/BROKER AUTHORIZATION

By submitting and signing this request:

- I, for the undersigned group, hereby request to designate the agent/broker named above as our authorized agent/broker for Kaiser Foundation Health Plans.
- I authorize our designated agent/broker to complete, sign and submit forms on behalf of the group without the need for a signature from the group. I agree to be bound by transactions performed by the agent/broker on our behalf. This includes our agent/broker submitting an *Employer Application* form to contract with Kaiser Permanente for Small Group health care coverage.
- I authorize you to discuss and provide group specific information to our designated agent/broker. This information includes, but is not limited to, our group plan agreement, rates, benefits, payment information and, to the extent permitted by applicable law, protected health information (PHI).

5 AGREEMENT AND SIGNATURE

Domestic Partner Coverage: Coverage for state-registered domestic partners is included in all small group plans. You may also offer coverage to those who are not registered with this state. Kaiser Permanente is not advising on whether or not the law requires coverage of these individuals. Please seek guidance from your legal counsel on dependent coverage obligations.

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

- My company is automatically enrolled in on-line billing and prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement. For any questions, please call **800-731-4661**.
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- My company's eligibility data provided to Kaiser Permanente will include coverage effective dates for 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 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 and maintain records of enrollment/wavier forms indefinitely, and upon request will produce documentation relating to a specific member to Kaiser Permanente at any time.
- My company may be subject to a recertification process to ensure my company meets all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.
- Upon request, my company will furnish to KFHP or KPIC all data necessary to verify company and employee eligibility including, but not limited to, data proving compliance with the underwriting requirements and terms of the group agreement.

I have read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which is available at **kp.org/smallbusinessguidelines/ca** and may be included with my rate quote.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law.

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 if I have an authorized agent/broker of record and/or have authorized General Agent access, then those parties and their support staff currently on file with Kaiser Permanente will have access to my company-specific information. They're able to service my organization and to act or change company information on my behalf. Access to my account.kp.org group account will be granted to my agent/broker who may delegate authority to their support staff. This information may include, but isn't limited to, renewal notices, group agreements, rates, benefits, and protected health information (PHI).

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 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.

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.

CALIFORNIA FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a health plan or an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance benefits, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the state's regulatory agency. For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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 contract signer (print name)	Company title (print)
Signature X	Date

**Disputes arising from the fully insured Kaiser Permanente Insurance Company (KPIC) coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion 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.*