

To help us process your enrollment accurately and quickly, complete and submit the following documents. Please use black ink.

If you have any questions, contact your broker or Kaiser Permanente sales representative.

1 New Group Application

Please be sure to provide **all** requested information on the application. The implementation of your group's coverage could be delayed if your application is not completely filled out and signed. Complete the broker authorization section only if you have a broker.

Note: Any group that is part of an existing Kaiser Permanente contract and wishes to apply for coverage as a new, separate group does not qualify as new business and will not be re-rated.

2 Employee enrollment forms

Enrollment forms are included in the employee enrollment kits.

- **Employers** should complete all information in Section A of the enrollment form.
- **Enrolling employees** should complete Sections B through E (including Social Security numbers and dates of birth for all family members, if applicable) and sign and date the form.

Please be sure that your employees retain a copy of their enrollment forms. They will need this information, particularly the customer ID number, plan name, and effective date, to complete a *Temporary Membership ID* form (enclosed in the employee enrollment kit) for accessing care before they receive their member ID cards.

3 Declination of Coverage form

All eligible employees who refuse coverage must sign the *Declination of Coverage* form.

Note: A minimum of 70 percent of all eligible employees must have some form of group health plan coverage.

4 DE 9C (Quarterly Wage Report) and/or payroll reports

Please provide one of the following:

- Your most recent DE 9C filing that shows a full quarter of data **plus** payroll records for the last 30 days showing employees hired after the DE 9C filing
- At least six weeks of payroll records that show two or more eligible employees for the entire period

On the DE 9C and/or the payroll records, note the status of each employee using the following codes:

- KP – enrolling with Kaiser Permanente
- AC – alternate carrier
- D – declining
- T – terminated
- NE – not eligible (specify reason)

Note: Eligible owners or officers who are not listed on the DE 9C or payroll report count toward the two eligible employee minimum.

If you have employees who have not been with the company long enough to appear on your most recent DE 9C filing or payroll records, please also complete the *New Employee Eligibility Documentation* form.

5 Proprietor/Partner/Corporate Officer Eligibility Statement

Each proprietor, partner, or corporate officer who is not listed on the DE 9C or payroll report should complete and sign this form.

(continues)

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6 Additional ownership/business validation documentation

Please provide the preferred documentation (listed in bold) for your type of business. If the preferred documentation is not available, please provide an alternative, as shown.

▪ **Sole proprietorship (owner and employee[s])
IRS Schedule C (Form 1040)**

Alternatives: business license or equivalent, such as fictitious business name statement, professional license, business tax certificate, or seller's permit

▪ **Spouse co-owners (qualified joint venture)
IRS Form 1040 and separate Schedule C forms for husband and wife**

Alternatives: jointly filed IRS Form 1040 for a newly formed business or a marriage license for newlyweds

▪ **Partnership (including spouse co-owners)
IRS Schedule K-1 (Form 1065)**

Alternatives: partnership agreement signed by all partners plus a federal EIN assignment letter or any other government-issued document that shows your EIN

▪ **Corporation**

IRS Schedule K-1 (Form 1120S) for S corporations

Alternatives: IRS Form 1120 (pages 1 and 2) with Schedule E for C corporations or Statement of Information (Form LLC-12)

▪ **Limited liability company (LLC)**

Applicable sole proprietorship, corporation, or partnership IRS tax forms

Alternative: Statement of Information (Form LLC-12)

7 Initial premium payment

When you submit your application, also include one of the following:

- A **copy** of a business check payable to Kaiser Permanente in the amount of the first month's premium
- A completed *Authorization for Initial Payment by Electronic Check* form (attached)

Once your group has been approved, we will provide you with a mailing address for submitting the original check or we will debit your account for the premium amount, depending on which option you have chosen. Please note that the authorization for payment by electronic check applies only to your first payment.

Submitting enrollment materials

Brokers: Fax to your sales associate. For more information, call **1-800-789-4661**.

Employers: If you don't have a broker, fax your enrollment materials directly to your Kaiser Permanente sales representative, or to **1-800-369-8010**. For more information, call **1-800-730-4661**.

Please type or print clearly using black ink.

Effective date: _____

I Company Information¹			
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 proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company (LLC) <input type="checkbox"/> Other _____		In business since	SIC code
Total number of employees (including owners, partners, and corporate officers)		Total number of employees eligible for health coverage	
Note: Include in your count any employees, owners, partners, and corporate officers of affiliated companies that are eligible to file a combined return.			
II 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.			
Company contribution for employees:		Company contribution for dependents:	
\$ _____ or _____ % of the premium		\$ _____ 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			
III Eligible Employees		IV Waiting Period	
Coverage will be offered to employees working (check one): <input type="checkbox"/> 20 hours or more per week <input type="checkbox"/> 30 hours or more per week		Benefits are effective the first of the month following (check one): <input type="checkbox"/> Date of hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days	
V Other Medical Insurance Coverage			
Does your company have or has it ever had group insurance through Kaiser Permanente? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Customer ID #/Group #:			
Does your company currently have active group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of carrier:			
VI Continuation Coverage^{2,3}			
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?	
VII Workers' Compensation Coverage		VIII ERISA Status	
Do you have workers' compensation coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Name of carrier:		Is your company subject to ERISA? ⁴ <input type="checkbox"/> Yes <input type="checkbox"/> No Note: If you do not select an answer, we will record your status as Yes.	

Company name: _____

IX Contract Signer Information			
Name of contract signer		Title	
Address			
City		State	ZIP
Office phone	Fax	Cell phone	
Contact preference (check one): <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail		Email	
X Contract Delivery Preference			
We will deliver your Kaiser Foundation Health Plan (KFHP) health plan/Kaiser Permanente Insurance Company (KPIC) contracts 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.)			
XI Billing Contact Information			
Authorized billing contact		Title	
<input type="checkbox"/> Check here if this person is authorized to make changes to your contract.			
Address			
City		State	ZIP
Office phone	Fax	Cell phone	
Contact preference (check one): <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail		Email	

Company name: _____

XII Interested Party			
(An <i>interested party</i> is an individual authorized to access private information about your group account.)			
Interested party contact name		Title	
<input type="checkbox"/> Check here if this person is also authorized to make changes to your contract.			
Address			
City		State	ZIP
Office phone	Fax	Cell phone	
Contact preference (check one): <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail		Email	
XII Interested Party			
Interested party contact name		Title	
<input type="checkbox"/> Check here if this person is also authorized to make changes to your contract.			
Address			
City		State	ZIP
Office phone	Fax	Cell phone	
Contact preference (check one): <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail		Email	
XIII Authorized Agent/Broker of Record for Kaiser Foundation Health Plan, Inc.			
(Complete only if you have a broker.)			
Agent name		License number	
Office phone	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: _____

XIV Medical Plan Options⁵

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?⁶ Yes No

- | | | | | | |
|--|---|---|---|------------------------------------|------------------------------------|
| Copayment HMO plans | <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 |
| HSA-qualified deductible HMO plans | <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 | | |
| Deductible HMO plans | <input type="checkbox"/> \$30/\$1,000 plan | <input type="checkbox"/> \$30/\$1,500 plan | <input type="checkbox"/> \$40/\$2,000 plan | | |
| Deductible HMO plans with HRA | <input type="checkbox"/> \$30/\$1,500 plan with HRA | <input type="checkbox"/> \$30/\$2,500 plan with HRA | | | |
| Point-of-service (POS) plans⁷ | <input type="checkbox"/> POS + GIFT plan ⁸ | <input type="checkbox"/> \$35 POS plan | | | |
| Preferred provider organization (PPO) plans⁷ | <input type="checkbox"/> \$40/\$1,000 plan | <input type="checkbox"/> \$40/\$2,500 plan with HSA | | | |

XV Dental Plan Options^{5,9}

Please select no more than one plan.

- | | | | | |
|-----------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--|
| Delta Dental Premier | <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) |
| Delta Dental PPO | <input type="checkbox"/> PPO D 1500 | <input type="checkbox"/> PPO E 1000 | <input type="checkbox"/> PPO E 1500 | |
| Dental Care HMO | <input type="checkbox"/> 13B HMO | <input type="checkbox"/> 10A HMO | | |

XVI Chiropractic Plan Options^{5,9}

Please select the plan(s) you would like to offer.¹⁰

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

¹ By giving us your contact information, you agree to be contacted by a Kaiser Permanente representative by phone, fax, or email.

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.

³ If you use a third-party administrator (TPA), please contact your Kaiser Permanente representative.

⁴ 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 advisor before responding.

⁵ 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) plan are underwritten by Kaiser Foundation Health Plan, Inc. Kaiser Permanente Insurance Company, a subsidiary of KFHP, underwrites the PPO plans and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic benefit is administered by American Specialty Health Plans of California, Inc. The chiropractic/acupuncture benefit is administered by Private Healthcare Systems.

⁶ A group of one to two subscribers can offer one plan. A group with three to five subscribers can offer one or two plans. A group with six or more subscribers can offer one or more plans.

⁷ For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

⁸ GIFT (gamete intrafallopian transfer) is an infertility treatment that involves removal, preparation, and reimplantation of ovum.

⁹ Dental and chiropractic plans are available only when purchased with a health plan. Out-of-state employees are not eligible for dental or chiropractic benefits.

¹⁰ Chiropractic benefits and chiropractic/acupuncture benefits cannot be combined with any HSA-qualified deductible HMO plan or the PPO with HSA plan.

Company name: _____

XVII Important Information – please read carefully

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc. (Health Plan), I agree that my company will make the minimum contribution toward the health care premiums as described in the Enrollment Provisions, that prepaid monthly premiums should be posted to Kaiser Permanente’s account by the due date on the Kaiser Permanente billing statement, that my company will use enrollment application forms that are provided or approved by Health Plan, and that my company will abide by the contract provisions.

Kaiser Permanente deductible plans are designed and priced based on the assumption that members participate in sharing the costs of their care. Employers funding cost share through direct reimbursements affects the way members utilize their plan, invalidating some of the assumptions we use to set benefits and pricing. Increased utilization results in an increase in premiums for all plan members. For this reason, Kaiser Permanente restricts employers from funding or directly reimbursing employee cost share, except as outlined below.

The undersigned group (“Group”) agrees to the following conditions when Group chooses to offer one or more Kaiser Permanente small business deductible plans.

- Group may not fund or directly reimburse members for any Kaiser Permanente deductibles, coinsurance, or copayments with the exception of designated health reimbursement arrangement (HRA) plans. This includes employer reimbursements of employee cost share through employee flexible spending accounts (FSAs) or limited purpose FSAs.
- Group can fund an employee’s health savings account (HSA) only if the employee is enrolled in a Kaiser Permanente HSA-qualified Deductible HMO Plan. Contributions must be made in accordance with the federal tax laws for HSAs.

Small group contracted premiums are set annually and do not allow for small group re-rating. Brokers who have advised small business clients to fund or directly reimburse employees for deductible plan expenses in violation of our policies will not receive sales commissions (or rewards compensation) from Kaiser Permanente. Groups in violation of our policies may be subject to termination or nonrenewal.

Your group may be subject to recertification.

Birthday billing – While group rates are guaranteed for 12 months, an individual subscriber within a group will experience a premium increase if his/her birthday ages him/her up to the next age band within a contract year. This subscriber premium increase will take effect the first of the month following the subscriber’s birthday. For example, if a group member is age 39 and turns 40 (or is age 49 and turns 50), that subscriber’s rate will go up the following month. Age bands are <30, 30–39, 40–49, 50–54, 55–59, 60–64, and 65 or older.

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.

I certify, to the best of my knowledge and beliefs, 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.

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

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 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 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* and in the *Certificate of Insurance*.

* Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 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.

Signature is required.

Authorized company signer (Please print name.)

Title

X

Authorized signer’s signature (Use black ink.)

Date

RETURN FAX NUMBER _____ ATTN _____

IMPORTANT: Do not mail original application or check.

APPLICANT INFORMATION – ELECTRONIC CHECK AUTHORIZATION

Company name _____ **Customer ID** _____

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to withdraw from my account just the first month's premium based on the facsimile copy of said premium check upon approval of the attached application. This payment will be electronically withdrawn from my bank account for the above-named group using the information provided.

Amount of premium \$ _____

Financial institution _____

Transit routing number _____ **Bank account number** _____

Bank account holder name _____

Bank account holder address _____

This transaction will appear on your next bank statement as an Automated Clearing House (ACH) transaction.

If this item is returned unpaid, I authorize Kaiser Foundation Health Plan, Inc., to resubmit the item and authorize an additional returned payment fee for up to the maximum amount as allowed by the state to be charged to this account. I also acknowledge that Kaiser Permanente will not be responsible for any fees incurred if the original check is mailed and cashed and for any fees owed to the financial institution.

Authorized bank account holder signature **Date**

ATTACH PREPRINTED, VOIDED CHECK

The billing department needs the most accurate information to debit your account. Therefore, the voided check is necessary for processing. Please note we are unable to accept the following checks and account types: third-party checks, credit card checks, cashier's checks, money orders, traveler's checks, official checks, government checks.

**PLEASE ATTACH
PREPRINTED, VOIDED CHECK HERE**

Confidentiality note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient or the person responsible for delivering it to the recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information in the transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. Thank you.