KAISER PERMANENTE®

Oregon Small Group

EMPLOYER APPLICATION

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St, Portland, OR 97232.

Group number ______________________

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)	Website

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 (5 digits)

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

Phone ( ) –	Fax ( ) –

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 customer ID and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

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

Will you be offering another carrier's small group 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.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No If *Yes*, please provide below:

Company name	☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal tax ID number	Phone ( ) –

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 _______________

Please provide the total number of **full-time and full-time-equivalent employees** during the prior calendar year on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to **healthcare.gov** or your legal counsel.* To qualify for small group coverage, your company must have at least 1 but no more than 50 full-time and full-time-equivalent employees during the prior 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 _________

If you're covering only a certain class of employees, specify the class(es) you're covering: ___________________

Total number of employees eligible for Medicare coverage: ______________

Hours per week employees must work to be eligible for coverage: _____________

Employee only coverage?[1] ☐ Yes ☐ No

[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 4980(H)(C)(2) of the Internal Revenue Code.

4 DOMESTIC PARTNER COVERAGE

Do you wish to offer Domestic Partner Coverage (opposite sex[2])? ☐ Yes ☐ No

[2]Registered same-sex domestic partner coverage is automatically provided according to Oregon law. Coverage for opposite sex domestic partners must be elected.

5 CONTINUATION COVERAGE

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA? ☐ Yes ☐ No

6 ERISA STATUS

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

[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.

7 MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA?[4] ☐ Yes ☐ No

[4]If your company employed 20 or more full-time and/or part-time employees for each working date for 20 or more calendar weeks in the current calendar year or preceding calendar year, your group is subject to this federal law.

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Business name (please print): ______________________

8 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)**

9 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. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title
Street address **(mailing address)**	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail		

10 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, but isn't authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed.

☐ **Check here if same as contract signer.**

First name	MI	Last name	
Street address	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail		

Business name (please print): ______________________

11 SELECT BENEFIT OFFERINGS

Please indicate below if you'll offer a single plan or bundled plans. When bundling medical plans, please note that you can choose no more than 1 Added Choice® plan. When bundling adult dental plans, please note you can only choose 1 traditional and 1 Dental Choice (PPO) plan. Indicate which specific plan or plans you wish to offer along with any dental plan(s). If you're offering different plans to different classes of employees, please provide details of plan offerings in the comments section.

Buy-up options — Any of the medical plans can be paired with a vision and/or alternative care buy-up option listed below, with the exception of the Standard plans. When selecting a plan with one of these buy-up benefit options, please check the appropriate box next to your medical plan selection.

Vision — $200/24 months Vision Hardware benefit and Vision Exam

Alternative care — $20 copay chiropractic, acupuncture, naturopathy/$25 copay massage with a 12-visit limit per calendar year/$1,000 benefit maximum for all services combined

		Buy-up option			
	Medical plan	**Vision**	**Alt Care**	**Both**	**HSA/HRA/FSA Selection(s)**
1st plan		☐	☐	☐	
2nd plan		☐	☐	☐	
3rd plan		☐	☐	☐	

	Dental plan
1st plan	
2nd plan	

12 PEDIATRIC DENTAL PLAN OPTIONS (Oregon Health Insurance Marketplace-certified)

We're required to include Oregon Health Insurance Marketplace–certified pediatric dental benefits with your medical plan(s). By enrolling in a Kaiser Permanente Small Business Medical Plan, each employee and each of his/her dependents will also be enrolled in a separate Oregon Health Insurance Marketplace–certified pediatric dental plan unless you've purchased other pediatric dental coverage certified by Oregon Health Insurance Marketplace. Employees won't be charged for pediatric dental coverage unless they have eligible children on the plan.

Please select your requested pediatric dental plan from the choices below.

We understand you may have acquired pediatric dental coverage from another carrier. Please select a plan in order to cover employees and/or dependents who may waive the alternate coverage.

☐ Plan Name: KP OR Choice 100 + Ortho Pediatric Dental Plan
☐ Plan Name: KP OR Choice 100 Pediatric Dental Plan
☐ Plan Name: KP OR Choice 80 Pediatric Dental Plan

If you've already acquired pediatric dental coverage from another carrier, we'll rely on your confirmation.

☐ Enroll my group in the pediatric dental plan along with the Small Business Medical Plan that I have chosen.
☐ I have purchased other pediatric dental coverage.

Business name (please print): ____________________

13A MEDICAL PLANS

Medical plan options			
Traditional Plans	The following consumer-directed health plans are available with traditional plans: FSA. KP OR Platinum 0/20 KP OR Gold 0/30		
Deductible Plans	The following consumer-directed health plans are available with deductible plans: HRA, FSA, stacked HRA/FSA.		
	KP OR Platinum 250/20 KP OR Gold 500/20 KP OR Gold 1000/20 KP Oregon Standard Gold	KP OR Gold 1500/35 KP OR Silver 2500/40 KP Oregon Standard Silver KP OR Silver 3500/40	KP OR Bronze 5000/50 KP OR Bronze 6600/40 KP Oregon Standard Bronze
HSA-Qualified High Deductible Health Plans	The following consumer-directed health plans are available with the High Deductible Health Plans: HRA, HSA, FSA, stacked HRA/FSA. KP OR Silver 2700/25% HSA KP OR Bronze 5200/20 HSA		
Added Choice® Deductible Plans*	The following consumer-directed health plans are available with Added Choice deductible plans: HRA, FSA, stacked HRA/FSA.		
	KP OR Platinum 250/10 3T POS KP OR Platinum 250/10 3T POS-OOA† KP OR Gold 600/35 3T POS	KP OR Gold 600/35 3T POS-OOA† KP OR Gold 1000/35 3T POS KP OR Gold 1000/35 3T POS-OOA†	KP OR Silver 2500/40 3T POS KP OR Silver 3000/40 3T POS-OOA†

*If you have employees who both live and work outside of our service area, we may be able to set them up on an Added Choice out-of-area plan. Rates and approval subject to approval by underwriting.

†POS OOA plans: Group must meet underwriting requirements to purchase.

13B ADULT DENTAL PLANS

Adult dental plan options (these stand-alone dental plans are available Outside Market only)			
Traditional	KP OR Adult Traditional 80 — $1000 Max KP OR Adult Traditional 80 — $50 Ded/$1000 Max KP OR Adult Traditional 80 — $100 Ded/$1000 Max KP OR Adult Traditional 80 — $1000 Max + Ortho KP OR Adult Traditional 100 — $1000 Max KP OR Adult Traditional 100 — $50 Ded/$1000 Max KP OR Adult Traditional 100 — $100 Ded/$1000 Max	KP OR Adult Traditional 100 — $1000 Max + Ortho KP OR Adult Traditional 100 — $1500 Max KP OR Adult Traditional 100 — $50 Ded/$1500 Max KP OR Adult Traditional 100 — $100 Ded/$1500 Max KP OR Adult Traditional 100 — $1500 Max + Ortho KP OR Adult Traditional 100 — $2000 Max KP OR Adult Traditional 100 — $50 Ded/$2000 Max	KP OR Adult Traditional 100 — $100 Ded/$2000 Max KP OR Adult Traditional 100 — $2000 Max + Ortho KP OR Adult Traditional 100 — $50 Ded/$2500 Max KP OR Adult Traditional 100 — $100 Ded/$2500 Max KP OR Adult Traditional 100 — $2500 Max + Ortho
Dental Choice (PPO)	KP OR Adult Choice 80 — $50 Ded/$1000 Max KP OR Adult Choice 80 — $100 Ded/$1000 Max KP OR Adult Choice 80 — $1000 Max + Ortho KP OR Adult Choice 100 — $50 Ded/$1000 Max KP OR Adult Choice 100 — $100 Ded/$1000 Max	KP OR Adult Choice 100 — $1000 Max + Ortho KP OR Adult Choice 100 — $50 Ded/$1500 Max KP OR Adult Choice 100 — $100 Ded/$1500 Max KP OR Adult Choice 100 — $1500 Max + Ortho KP OR Adult Choice 100 — $50 Ded/$2000 Max	KP OR Adult Choice 100 — $100 Ded/$2000 Max KP OR Adult Choice 100 — $2000 Max + Ortho KP OR Adult Choice 100 — $50 Ded/$2500 Max KP OR Adult Choice 100 — $100 Ded/$2500 Max KP OR Adult Choice 100 — $2500 Max + Ortho

Business name (please print): ______________________

14 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan of the Northwest (KFHPNW) 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.

15 FOOTNOTE INFORMATION

***Determining Group Size Under Oregon Law**

Oregon Administrative Rule (OAR) 836-053-0015 establishes the method for defining a small employer. This rule and its Exhibit provide specific details about how to count employees toward the small and large group size thresholds. Generally speaking, a small employer in Oregon is one that employed (on average, during the prior calendar year) 1–50 full-time employees, including full-time-equivalent employees. A prescribed calculation determines the number of full-time and full-time-equivalent employees. Companies with a common owner or that are otherwise related under certain rules of Section 414 of the Internal Revenue Code are generally combined and treated as a single group.

To be considered a small employer under Oregon law (OAR 836-053-0015), the employer must employ at least 1 common law employee **who is enrolled on the plan at the beginning of the plan year.**

For more information on how to count employees toward the 1–50 threshold, which employees to count, and how to identify controlled groups, refer to any of these sources:

- OAR 836-053-0015 (search for this OAR at www.oregon.gov/DCBS)
- Exhibit A to OAR 836-053-0015 (search for this Exhibit at www.oregon.gov/DCBS)
- IRS Publication, "Determining if an Employer is an Applicable Large Employer" www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer

You may also refer to healthcare.gov or your legal counsel for information on calculating the number of full-time, full-time-equivalent, and eligible employees.

An employee is considered a common law employee if the employer has the authority to direct and control the manner in which the services are performed by the individual. For more information, see Exhibit A to OAR 836-053-0015 (search for exhibit at www.oregon.gov/DCBS).

Business name (please print): ______________________

16 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To the best of my knowledge and belief, employment and other information on this application is complete and accurate. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of Kaiser Foundation Health Plan of the Northwest (KFHPNW). I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance.

Agent name | License number

Phone ( ) – | Fax ( ) – | Cell phone ( ) –

Email

Firm name | EIN/TIN | Kaiser Permanente broker firm ID

Street address | City | State | ZIP

Agent/broker signature X | Date

17 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHPNW, 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 KFHPNW 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 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 Rating and Underwriting Assumptions Policy, which may be included with my rate quote or, if not included, is available at online.

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 enrolling W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that the minimum participation requirement, based on group size: 1-3 eligible employees: 100% (valid waivers excluded); 4-50 eligible employees: 75% (valid waivers excluded) of eligible employees are covered by group coverage.

I attest that I have purchased pediatric dental coverage certified by Oregon Health Insurance Marketplace either through KFHPNW or through another carrier.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/nw**. 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. You may be guilty of insurance fraud if you knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Authorized company signer (please print name) | Title (please print)

Signature required for all Kaiser Permanente Plans X | Date