KAISER PERMANENTE®

Washington 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)

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 (5 digits)	Website
/ /			

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 ( ) –

3B EMPLOYEE COUNT

To qualify for small group coverage, your company must have at least 1 but no more than 50 employees on average during the previous calendar year. Please provide the total number of employees **(full-time and part-time).**

Total _____ Authorized company signer's initials _____

Business name (please print): _____

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 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 (non-state-registered[2])? ☐ Yes ☐ No

[2]As required by state law, coverage for state-registered domestic partners is included in all small group plans. Employers may choose to provide coverage for unregistered domestic partners.

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 don't 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.

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)**

Business name (please print): _____

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)	City	State	ZIP

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

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 ( ) –	Cellphone ( ) –

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

11 SELECT BENEFIT OFFERINGS

Please indicate below if you'll offer a single plan or bundled plans, along with any consumer-directed health care offerings you wish to include. When bundling medical plans, please note that you can choose no more than one Added Choice® plan. When bundling dental plans, please note you can choose only 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 class(es) of employees, please provide details of plan offerings in the comments section.

Any of the medical plans are available with a Vision Hardware and exam buy-up option. When selecting a plan with this built-in benefit, please check the box in the vision column.

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

	Medical	**Vision***
1st plan		☐
2nd plan (if bundled)		☐
3rd plan (if bundled)		☐
HSA/HRA/FSA selection(s)		☐

	Dental
1st plan	
2nd plan (if bundled)	
Pediatric dental plan	
HSA/HRA/FSA selection(s)	

Business name (please print): _____

12 MEDICAL PLANS*

TRADITIONAL PLANS

The following consumer-directed health plans are available with traditional plans: FSA.

KP WA Platinum 0/20	KP WA Gold 0/30

DEDUCTIBLE PLANS

The following consumer-directed health plans are available with deductible plans: HRA, FSA, stacked HRA/FSA.

KP WA Platinum 250/20	KP WA Gold 1500/35	KP WA Bronze 5000/50
KP WA Gold 500/20	KP WA Silver 2500/40	KP WA Bronze 6600/40
KP WA Gold 1000/20	KP WA Silver 3500/40	

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 WA Silver 2700/25% HSA	KP WA Bronze 5200/20 HSA

ADDED CHOICE® DEDUCTIBLE PLANS

The following consumer-directed health plans are available with the Added Choice deductible plans: HRA, FSA, stacked HRA/FSA.

KP WA Platinum 250/10 3T POS	KP WA Gold 1000/35 3T POS
KP WA Gold 600/35 3T POS	KP WA Silver 2500/40 3T POS

13A ADULT DENTAL PLAN OPTIONS (AGE 19 AND OLDER)‡

TRADITIONAL

KP WA Adult Traditional 80 — $1000 Max	KP WA Adult Traditional 100 — $50 Ded/$1000 Max	KP WA Adult Traditional 100 — $100 Ded/$1500 Max	KP WA Adult Traditional 100 — $2000 Max + Ortho
KP WA Adult Traditional 80 — $50 Ded/$1000 Max	KP WA Adult Traditional 100 — $100 Ded/$1000 Max	KP WA Adult Traditional 100 — $1500 Max + Ortho	KP WA Adult Traditional 100 — $50 Ded/$2500 Max
KP WA Adult Traditional 80 — $100 Ded/$1000 Max	KP WA Adult Traditional 100 — $1000 Max + Ortho	KP WA Adult Traditional 100 — $2000 Max	KP WA Adult Traditional 100 — $100 Ded/$2500 Max
KP WA Adult Traditional 80 — $1000 Max + Ortho	KP WA Adult Traditional 100 — $1500 Max	KP WA Adult Traditional 100 — $50 Ded/$2000 Max	KP WA Adult Traditional 100 — $2500 Max + Ortho
KP WA Adult Traditional 100 — $1000 Max	KP WA Adult Traditional 100 — $50 Ded/$1500 Max	KP WA Adult Traditional 100 — $100 Ded/$2000 Max	

DENTAL CHOICE (PPO)

KP WA Adult Choice 80 — $50 Ded/$1000 Max	KP WA Adult Choice 100 — $100 Ded/$1000 Max	KP WA Adult Choice 100 — $1500 Max + Ortho	KP WA Adult Choice 100 — $50 Ded/$2500 Max
KP WA Adult Choice 80 — $100 Ded/$1000 Max	KP WA Adult Choice 100 — $1000 Max + Ortho	KP WA Adult Choice 100 — $50 Ded/$2000 Max	KP WA Adult Choice 100 — $100 Ded/$2500 Max
KP WA Adult Choice 80 — $1000 Max + Ortho	KP WA Adult Choice 100 — $50 Ded/$1500 Max	KP WA Adult Choice 100 — $100 Ded/$2000 Max	KP WA Adult Choice 100 — $2500 Max + Ortho
KP WA Adult Choice 100 — $50 Ded/$1000 Max	KP WA Adult Choice 100 — $100 Ded/$1500 Max	KP WA Adult Choice 100 — $2000 Max + Ortho	

‡Pediatric dental care is included in the medical plan for members 18 and younger.

Business name (please print): _____

13B PEDIATRIC DENTAL PLAN OPTIONS (AGE 18 AND YOUNGER)

DENTAL CHOICE PPO

	KP WA Choice 100 Pediatric Dental Plan	KP WA Choice 100 + Ortho Pediatric Dental Plan

13C FAMILY DENTAL PLAN OPTIONS (ADULT BENEFITS AND QUALIFIED PEDIATRIC DENTAL PLANS)

DENTAL CHOICE (PPO)

	KP WA Adult Choice 100 + Child Ortho

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 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've 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	Cellphone
( ) –	( ) –	( ) –

Email

Firm name	EIN/TIN	Kaiser Permanente broker firm ID

Street address	City	State	ZIP

Agent/broker signature	Date
X	

Business name (please print): _____

16 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 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 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 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. It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties 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