

To help us process your enrollment accurately, please be sure all the items listed below are completed.

New Group Application

- The application must be completed, including the signature of the authorized company officer and date of signature.
- If the application is submitted without your signature, it will be returned, delaying implementation of your group's coverage.
- Make sure that all broker information is completed, if applicable.
- Make sure your contract delivery method is indicated.

Employee enrollment application

It is very important that you communicate the type of plan and plan name to your employees. They will need to check the plan name in the following places:

- on the cover of their enrollment booklets, in order to reference information about their benefits, and
- on their *Temporary Membership ID Form*, which is located in the employee enrollment booklet.

Make sure all enrolling employees complete, sign, and date an enrollment form located in the employee enrollment booklet. The form must include the following:

- Company name
- New group account box checked
- Social Security numbers and dates of birth for all family members to be included in the coverage
- Employee's signature on the application

Declination of coverage

All eligible employees who are refusing coverage must complete the *Declination of Coverage* form. A minimum of 70 percent of all eligible employees must have group health plan coverage.

Initial premium payment

At the time of enrollment, a copy of a business check in the amount of the first month's premium and payable to Kaiser Permanente must be submitted with your application. For your convenience, the attached *Electronic Check Authorization* form may be submitted instead of a check.

Once your group has been approved, a mailing address for submitting the original check will be provided or the premium will be withdrawn directly from your account depending on which option you have chosen.

Company contribution to employee premium

The contribution can be a percent or a fixed dollar amount. Minimum contribution is at least 50 percent of the premium of the lowest plan offered by the company.

Proprietor/Partner/Corporate Officer Form

Must be completed for each proprietor/partner/corporate officer enrolling not listed on the DE 6 or payroll report.

Owner-only groups

Owner-only groups enrolling, such as a husband and wife enrolling with or without children, must qualify as a business by providing the *Proprietor/*

Partner/Corporate Officer Form and one additional document, including but not limited to the following:

- Business license
- DBA fictitious business name statement
- Contractor's license
- Seller's permit

Sole proprietorship

If a co-owner is a spouse and is not listed, the following must be submitted, along with the *Proprietor/Partner/Corporate Officer Form*:

- 1040 Schedule C for the preceding calendar year
- One of the eligibility documents listed under the "Owner-only groups" section

Corporations

For corporations, submit the *Proprietor/Partner/Corporate Officer Form* and one additional document, including but not limited to the following:

- Articles of incorporation including officers and Schedule K-1
- Statement of Information by Domestic Stock Corporation
- Shareholder/Stock certificates
- Tax form 1120 or 2553

DE 6 (Quarterly Wage Report) or payroll report

Please include:

- DE 6 from the previous quarter (note updated employee status, i.e., part-time, full-time, or terminated, and name of other carrier if the employee has other group coverage or through spouse's employer)
- Payroll records from within the last 30 days for employees hired after the DE 6 filing
- Proof of owner's/employer's eligibility, if the owner/employer is not listed on the DE 6 (See *Proprietor/Partner/Corporate Officer Form* section.)

Groups that do not qualify as new business

If your group falls into one of the categories below, it is not considered new business and does not qualify for new business rates. Your group will be issued the same risk adjustment factor (RAF) as the group it was with previously.

- A resold existing Kaiser Permanente, CaliforniaChoice, or Choice Solution group
- A group previously included in an existing Kaiser Permanente contract that now wishes to enroll directly with Kaiser Permanente (for example, associations) will have the RAF determined by Actuarial.

Brokers: Submit enrollment materials

Fax is the preferred method for submitting enrollment materials. Send the fax to your sales associate. For more information, call **1-800-789-4661**.

Employers: Do you have a broker? If not, please fax your application to **1-800-369-8010**, or directly to your sales representative.

Effective date _____

This application for Kaiser Foundation Health Plan, Inc. (Health Plan), benefits is intended for the company below. Please use black ink.

Company information

Company name _____		Tax ID number _____	
Doing business as _____		Website _____	
Street address (California only; no P.O. boxes) ()	City ()	State	ZIP
Phone ¹	Fax ¹	E-mail ¹	

<p>Type of company: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Other</p> <p>In business since _____ SIC/NASIC code _____</p> <p>Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under Health Plan.</p> <p>Waiting period: Benefits are effective the first of the month following: (Check one)</p> <p><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</p> <p>Company health plan premium contribution for all employees: \$ _____ or _____ %³</p> <p><input type="checkbox"/> Company's lowest plan's premium <input type="checkbox"/> Employee's selected plan premium</p> <p>Company premium contribution for employee's dependents: <input type="checkbox"/> None <input type="checkbox"/> \$ _____ or <input type="checkbox"/> _____ %</p>	<p>Do you have or have you previously had group insurance through Kaiser Permanente? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, group number _____</p> <p>Does your company currently have active group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of carrier _____ Number of employees enrolled _____</p> <p>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 If yes, name of carrier _____</p> <p>What type of continuation coverage are you subject to?² <input type="checkbox"/> Federal COBRA (20+ employees) <input type="checkbox"/> Cal-COBRA (2-19 employees)</p> <p>Number of COBRA or Cal-COBRA enrollees (applying for health coverage) _____</p> <p>Do you have workers' compensation coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of carrier _____</p>
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¹By giving us your contact information, you agree to be contacted by a Kaiser Permanente representative by phone, fax, or e-mail.

²The 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.

³The minimum fixed dollar amount is >= 50 percent of lowest plan premium. Minimum percent that can be used is 50 percent.

 Company name

Customer contact details (Please use black ink.)					
1. Group officer (authorized contract signer)		Title	E-mail ¹		
<input type="checkbox"/> Name and title of contact authorized to receive contract and make contract changes ()		Address	City	State	ZIP
Phone ¹	Ext.	Fax ¹	Cell ¹		
Delivery preference?	<input type="checkbox"/> E-mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Mail		
<input type="checkbox"/> Name and title of contact authorized to receive billing statements ()		Address	City	State	ZIP
Phone ¹	Ext.	Fax ¹	Cell ¹		
Delivery preference?	<input type="checkbox"/> E-mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Mail		
<input type="checkbox"/> Name and title of interested party authorized to access information about your account		<input type="checkbox"/> Check here if this person is authorized to make changes to your contract.			

Contract delivery
We will deliver your KFHP health plan/KPIC health insurance contracts on our website unless you indicate below that you want 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 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 receive your KPIC contracts by mail in paper format)

<input type="checkbox"/> I authorize the following individual to act as broker of record for Kaiser Foundation Health Plan, Inc.			
Agent name		Agent e-mail ¹	
Agent license number	Agent phone number ¹	Agent fax number ¹	
Firm name		Kaiser Permanente broker ID	
Firm address	City	State	ZIP
Broker/Agent: If you have not registered as a firm or agent with Kaiser Permanente, please call Broker Administration at 1-800-789-4661 .			

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

Company name

Effective date

Plan options	
Please select the plan(s) you would like to offer. ¹ For more information on the plans listed below, please contact your sales representative or broker to obtain a copy of the <i>Plan Highlights</i> .	
Are you planning on selecting two or more plans from below? ¹	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to receive a bill for each location?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Copayment plans	<input type="checkbox"/> \$50 plan <input type="checkbox"/> \$30 plan <input type="checkbox"/> \$20 plan <input type="checkbox"/> \$15 plan <input type="checkbox"/> \$5 plan
Deductible HMO plans	<input type="checkbox"/> \$40/\$2,000 plan <input type="checkbox"/> \$30/\$1,500 plan <input type="checkbox"/> \$30/\$1,000 plan
HSA-qualified deductible HMO plans	<input type="checkbox"/> \$30/\$3,000 plan with HSA <input type="checkbox"/> \$0/\$2,700 plan with HSA <input type="checkbox"/> \$0/\$2,000 plan with HSA
Deductible HMO plans with HRA²	<input type="checkbox"/> \$30/\$2,500 plan with HRA <input type="checkbox"/> \$30/\$1,500 plan with HRA
Point-of-service (POS) plans³	<input type="checkbox"/> \$35 POS plan <input type="checkbox"/> POS + GIFT ⁴ plan
Preferred provider organization (PPO) plans³	<input type="checkbox"/> \$40/\$2,500 plan with HSA <input type="checkbox"/> \$40/\$1,000 plan

Dental plans and chiropractic benefits⁵																
Dental option (select only one plan)	<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 5px;">Delta Dental Premier</td> <td style="padding: 2px 5px;"><input type="checkbox"/> Plan C</td> <td style="padding: 2px 5px;"><input type="checkbox"/> Plan D</td> <td style="padding: 2px 5px;"><input type="checkbox"/> Plan E</td> <td style="padding: 2px 5px;"><input type="checkbox"/> Plan E with Ortho (requires at least 10 subscribers)</td> </tr> <tr> <td style="padding: 2px 5px;">Delta Dental PPO</td> <td style="padding: 2px 5px;"><input type="checkbox"/> PPO D 1500</td> <td style="padding: 2px 5px;"><input type="checkbox"/> PPO E 1000</td> <td colspan="2" style="padding: 2px 5px;"><input type="checkbox"/> PPO E 1500</td> </tr> <tr> <td style="padding: 2px 5px;">DeltaCare HMO</td> <td style="padding: 2px 5px;"><input type="checkbox"/> DeltaCare 10A</td> <td colspan="3" style="padding: 2px 5px;"><input type="checkbox"/> DeltaCare 13B</td> </tr> </table>	Delta Dental Premier	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<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		DeltaCare HMO	<input type="checkbox"/> DeltaCare 10A	<input type="checkbox"/> DeltaCare 13B		
Delta Dental Premier	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<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													
DeltaCare HMO	<input type="checkbox"/> DeltaCare 10A	<input type="checkbox"/> DeltaCare 13B														
Chiropractic option⁶	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Chiropractic/Acupuncture benefit for the \$40/\$1,000 PPO plan only															

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. (KFHP). Kaiser Permanente Insurance Company (KPIC), 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.

¹Groups with three to five subscribers are eligible to enroll in one or two Kaiser Permanente plans. Groups with six or more subscribers are eligible to enroll in one or more plans.

²Employer must fund at least 25 percent of the subscriber's deductible for the \$30/\$1,500 Deductible HMO Plan with HRA and at least 40 percent of the subscriber's deductible for the \$30/\$2,500 Deductible HMO Plan with HRA.

³For 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.

⁴GIFT (gamete intrafallopian transfer) is an infertility treatment that involves removal, preparation, and reimplantation of ovum.

⁵Dental and chiropractic plans are only available when purchased with a health plan.

⁶Chiropractic benefits and chiropractic/acupuncture benefits cannot be combined with any HSA-qualified deductible HMO plan or the PPO with HSA plan.

Company name

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 your account by the due date on your 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 non-renewal.

Your group may be subject to recertification prior to renewal.

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 29 or younger, 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 belief, 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 cancelled or the applicable dues/rates may be adjusted.

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 a group that is subject to ERISA, 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 Plans; 2) the PPO and Out-of-Area Indemnity 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 _____ **Company ID** _____

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to withdraw from my account the first month's premium only 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**

Employer signature **Title** **Date**

ATTACH PRE-PRINTED, 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
PRE-PRINTED, 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.