

Group number _____

Company name _____

All subscribers must be covered by workers' compensation, unless not required by law to be covered.

I attest that the following information is correct.

Do you have workers' compensation coverage?

Yes Workers' compensation carrier _____

No

Exempt Reason _____

I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc., with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage from Health Plan for the above-named employer group.

Please note: Owner/partners are covered for 24 hours with Kaiser Permanente and are not required to cover themselves for workers' compensation.

Company officer (Please print name.)

Title

X

Company officer's signature (**Use black ink.**)

Date