



NEW GROUP APPLICATION

This application for Kaiser Foundation Health Plan, Inc. (Health Plan), benefits is intended for the company below. (Attach additional sheets if necessary. Please print or type in black ink only.)

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 *Plan Highlights*.

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
HSA-qualified deductible HMO plans	<input type="checkbox"/> \$30/\$2,700 plan with HSA	<input type="checkbox"/> \$0/\$2,700 plan with HSA	<input type="checkbox"/> \$0/\$2,200 plan with HSA	<input type="checkbox"/> \$0/\$1,500 plan with HSA	
Deductible HMO plans	<input type="checkbox"/> \$30/\$1,500 plan	<input type="checkbox"/> \$30/\$1,000 plan			
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 plan + GIFT ⁴			
PPO insurance plans³	<input type="checkbox"/> \$40/\$2,500 plan with HSA	<input type="checkbox"/> \$40/\$1,000 plan			

Check here if you are selecting two or more plans from the above.¹

I want to offer my employees dental and/or chiropractic coverage. (Select one dental plan only.)⁵

Dental options	Add fee-for-service dental plan	<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)
	Add PPO dental plan	<input type="checkbox"/> PPO D 1500	<input type="checkbox"/> PPO E 1000	<input type="checkbox"/> PPO E 1500	
	Add HMO dental plan	<input type="checkbox"/> DeltaCare 10A	<input type="checkbox"/> DeltaCare 13B		
Chiropractic option⁶	<input type="checkbox"/> Add chiropractic option				

The traditional HMO plan and the in-network portion of the point-of-service (POS) plans are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the PHCS network (PPO) plan and the out-of-network portion of the POS plan as well as the dental plans. KPIC is a subsidiary of KFHP. Chiropractic services are administered by American Specialty Health Plans of California, Inc.

Company information

Company name _____

Street address (California only: no P.O. boxes) _____ City _____ State _____ ZIP _____
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Phone _____ Fax _____ E-mail _____
 (By giving Kaiser Permanente your fax number and e-mail address, you agree to receive faxes and e-mail from us.)

Type of company: Corporation Partnership Sole proprietor Other _____

In business since _____ SIC/NASIC code _____

Have you had previous group insurance through Kaiser Permanente? Yes No If yes, group number _____

Is your company currently active with another health insurance carrier? Yes No If yes, name of other carrier _____

Will you be offering another carrier's health care plans to your employees? Yes No If yes, name of health care plan carrier _____
 Number of employees enrolled _____

Do you have workers' compensation coverage? Yes No If yes, name of carrier _____

Number of COBRA or Cal-COBRA enrollees (applying for health coverage) _____

What type of continuation coverage are you subject to? Federal COBRA Cal-COBRA

If federal COBRA, how would you like your COBRA enrollees to be billed? Group-billed or third-party administrator Kaiser Permanente-billed

Note: 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 COBRA members for applicable premiums (the employer authorizes Health Plan to add an administrative charge for this service); and terminating COBRA members for nonpayment of COBRA premiums or for expiration of the expected time limit that the employer specifies for COBRA coverage.

¹For more information on setting up a multiple plan offering for your group, please contact your broker. Groups 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, 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 an 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 options are only available when purchased with health coverage.
⁶Chiropractic services cannot be combined with any deductible plan with an HSA option, the PPO plan, or the PPO plan with HSA option.

Company name _____

NEW GROUP CHECKLIST

Easy steps to enrollment

To help us process your enrollment accurately, please be sure all the items listed below are completed and submitted to your broker before the effective date of coverage.

 New Group Application

- The application must be completed, including the signature of the owner 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.

 Employee application

If your group is enrolling in a copayment or deductible plan, 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:

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

Make sure all 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
- A completed *Student Certification Form* for dependents who are 19 to 24 years old
- Employee's/Subscriber'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 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.

 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 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 at least one of the bulleted documents listed below, plus the business license and the *Proprietor/Partner/Corporate Officer Form*:

- Articles of incorporation (state seal affixed) 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

- Most recent DE 6 or payroll report will be required for each employee for verification of eligibility
 - 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)
 - Payroll records 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.)
 - A copy of the Employment Development Department (EDD) response letter or application is required if the company recently established payroll. (If the EDD letter or application is not available, a second document may be required. See "Owner-only groups" section.)
- Note:** The DE 6 will suffice by itself if the owners and all employees enrolling in the plan are listed, and as long as Kaiser Permanente can verify the business. If not, Kaiser Permanente will require a second document, such as a business license or articles of incorporation.

 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 has spun off from.

- 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.

 Submit enrollment materials

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

Company name _____

Principal owners/Corporate officers

1. Name _____ Title _____ Social Security number/EIN _____

2. Name _____ Title _____ Social Security number/EIN _____

■ 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.

■ How long must a new hire be employed before being offered health care benefits? **Benefits are effective the first of the month following the waiting period. (Check one.)** Date of hire 30 days 60 days 90 days 180 days 365 days

■ Billing statements to be mailed to (person/title) _____ Address _____ City _____ State _____ ZIP _____

■ Contract to be mailed to (person/title) _____ Address _____ City _____ State _____ ZIP _____

Check here if this person is authorized to make changes to your contract.

■ Interested party (An interested party is authorized to access information about your account.)

Please complete, sign, and date below. I authorize the following individual to act as broker of record for Kaiser Foundation Health Plan, Inc.

Broker name _____ Firm name _____

Broker address _____ City _____ State _____ ZIP _____

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Phone _____ Fax _____

California L&D license # _____ Expiration date _____ Kaiser Permanente broker ID # _____

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.

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

- Groups offering one or more of Kaiser Permanente's small business deductible plans may not directly compensate employees for their health care expenses on an individual basis, per the rate assumptions for the plans.
- Kaiser Permanente small business deductible plans, with the exception of designated health reimbursement arrangement (HRA) plans, **must not** be used in conjunction with *deductible funding* or an HRA, either directly or through a third-party administrator, per the rate assumptions for the plans. The deductible funding policy states that certain Kaiser Permanente deductible plans may not be sold alongside other coverage that would reimburse a Kaiser Permanente member for costs such as copayments and deductibles.
- Group may make contributions to bona fide health savings accounts (HSAs), but Group's HSA contributions must be made in accordance with the requirements of all applicable law, including, but not limited to, the federal tax law "comparability" rules and annual limits on overall HSA contributions.
- Group understands that Kaiser Permanente deductible plans with HRA require that the HRA be administered by a third-party administrator.

Note: Your group may be subject to recertification upon renewal.

Note: Binding arbitration does not apply to disputes with KPIC level 2 or disputes with out-of-network providers.

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*.

X
 Company officer signature (Use black ink only.) _____ Company officer (Please print name.) _____ Title _____ Date _____

Initial Payment by Electronic Check Authorization for new small business accounts



RETURN FAX NUMBER _____ ATTN _____

IMPORTANT: Do not mail original application or check.

APPLICANT INFORMATION – ELECTRONIC CHECK AUTHORIZATION

Company name _____ Group number _____

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.