KAISER PERMANENTE®

Small Business

EMPLOYER'S CONFIRMATION OF WORKERS' COMPENSATION

1 COMPANY INFORMATION

Company name	Group ID

Phone	Fax
( ) –	( ) –

☐ Check here if phone or fax has changed.

2 WORKERS' COMPENSATION

All employees must be covered by workers' compensation, unless not required to be covered by law. I attest that the following information is correct.

☐ Workers' compensation carrier: _____

☐ Exempt – I'm exempt from providing workers' compensation coverage for the following reason:

_____

Please note: Owner/partners are covered by Kaiser Permanente 24 hours a day while at work and aren't required to cover themselves for workers' compensation.

3 READ AND SIGN

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company on behalf of the group. 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 company.

Authorized company signer (please print name)	Company title (please print)

Signature	Date
X	