KAISER PERMANENTE®

Small Business

PARTICIPATION AND CONTRIBUTION ATTESTATION

1 COMPANY INFORMATION

Company name	Group ID

Phone	Fax
( ) -	( ) -

☐ Check here if phone or fax has changed for the business.

2 EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Total _____

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year.

Total _____

3 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to employee 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 one only):**

☐ Lowest-priced plan offered by the employer ☐ All plans offered by the employer

Are you offering dependent coverage?* ☐ Yes ☐ No

Employer contribution (50%-100%): _____ % per employee _____ % per dependent **(optional)**

Employer contribution (fixed $): $ _____ per employee $ _____ per dependent **(optional)**

*If you have 50 or more 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 READ AND SIGN

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

I've read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which is available at **kp.org/smallbusinessguidelines/ca**.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I'll comply with the health plan's minimum participation requirements.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I'll be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

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

Signature	Date
X	