KAISER PERMANENTE®

Small Business
CHANGE OF OWNERSHIP

Effective date (first day of the month) /01/

Group ID

IMPORTANT INFORMATION

Please fax the complete **bill of sale, purchase agreement, or buy-sell agreement** with all required buyer and seller signatures along with this form to your Account Management Team: **amt@kp.org** or your broker.

Your new contract will mirror the existing contract, including plan selections (upgrades to plans aren't allowed midyear), and company contribution.

1 NEW COMPANY INFORMATION

Company name

Doing business as (DBA)	Website

Type of business: ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since (mm/dd/yyyy): / /	Federal tax ID (EIN) number	NAICS code (6 digits)

Physical street address **(no P.O. boxes)**	City	State	ZIP	County

Office phone ( ) –	Fax ( ) –

Do you have workers' compensation coverage? ☐ Yes ☐ No ☐ Pending

If *Yes* or *Pending,* name of carrier (indicate unknown or pending, if applicable):

Carrier policy #:

Hours per week employees must work to be eligible for coverage?

How many employees did you employ for at least 50% of the workdays of the preceding calendar year (Jan-Dec)?

2 COMPANY DEBT/LIABILITIES – KAISER PERMANENTE PREMIUMS

Please choose one of the options below.

☐ Group will retain current group ID. Group assumes all past-due premium liabilities.

☐ New group ID will be issued. Group assumes payment as of the effective date of acquisition/transfer. **Group will also submit the Change of Ownership Subscriber Transfer form.**

3 CONTRACT SIGNER INFORMATION

There's only one contract signer. This principal person is responsible for providing renewal information, and authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title

Mailing address	City	State	ZIP

Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

4 OTHER MEDICAL COVERAGE

Does your company or affiliated company(ies) have or has it ever had group coverage directly through Kaiser Permanente? If *Yes*, please provide the group ID and company name.

☐ Yes ☐ No Group ID: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal date: / /

Will you be offering a fully insured, age-rated, ACA-compliant small group metal or grandfathered (nonmetal) health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: **Number of employees enrolled:**

5 CONTRACT DELIVERY PREFERENCE

We'll deliver your Kaiser Foundation Health Plan, Inc. (KFHP)/Kaiser Permanente Insurance Company (KPIC) contracts online in a PDF file at **account.kp.org** unless you indicate below that you'd like your contract(s) mailed to you.

☐ I want to receive my contract(s) by mail.

6 BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information. Only one billing contact is allowed (additional names can be added as interested parties below).

First name	MI	Last name	
Mailing address	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

7 THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The TPA contact is an external person, company, or broker that's contracted for the purpose of administering the group's billing and enrollment or solely administering your COBRA benefits. This person will have access to group information.

☐ Add ☐ Change ☐ Remove

TPA company name

Will a TPA, including a broker, administer Federal COBRA? ☐ Yes ☐ No ☐ Check here if COBRA statement will be sent to a group's billing address.

Note: A TPA can't administer Cal-COBRA. TPA is for Federal COBRA administration only.

Effective date
/ /

First name	MI	Last name		
Mailing address	City	State	ZIP	
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –	
Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail			

8 INTERESTED PARTY CONTACT INFORMATION

An **interested party** is an individual authorized to discuss and receive group specific information, and is authorized to make changes to your contract, such as adding/deleting plans, adding/deleting employees, or increasing/decreasing company premium contributions.

Note: Your broker, if you have one, can't be an interested party.

First name	MI	Last name	
Mailing address	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

ADDITIONAL INTERESTED PARTY

First name	MI	Last name	
Mailing address	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

9 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

Complete only if you have a broker.

☐ Add ☐ Change ☐ Remove

Primary (authorized agent/broker)

Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID

Secondary (only if adding another firm; doesn't apply to a second agent/broker at the same firm)

Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID

If your broker hasn't registered as a firm or agent with Kaiser Permanente, please visit account.kp.org.

10 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

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.

All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.

11 READ AND SIGN

I affirm that I have authority to contract with KFHP and KPIC on behalf of the group, and I agree that:

- Prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement.
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- My company will abide by the contract provisions.

I've read, understood, and agreed to Kaiser Permanente's *Small Business Guidelines*, which may be included with my rate quote or, if not included, is available at **kp.org/smallbusinessguidelines/ca**.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I've chosen or change to in the future.

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.

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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*.

Authorized company signer (please print name)	Company title (please print)
Signature X	Date

**Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage aren't subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.*

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CHANGE OF OWNERSHIP SUBSCRIBER TRANSFER

IMPORTANT INFORMATION

Use this form to request subscriber/account transfers from one group ID to a new group ID due to *change of ownership*.

1. Subscriber transfers may only be requested by staff authorized by the customer to change membership records.
2. This form **can't** be used for new subscriber enrollments, dependent additions, or terminations. New subscriber enrollments and dependent changes require an Employee Enrollment or Employee/Dependent Change form be completed and signed by the subscriber.
3. Refer to your contract for your specific retroactivity policy.

For terminations, use the Subscriber Termination and Transfer form.

1 CUSTOMER INFORMATION

Company name	Group ID

2 TRANSFER REQUESTS

Subscriber full name (please only list the subscribers on the account. All dependents currently enrolled will automatically be transferred to the new group ID).	Date of birth (mm/dd/yyyy)	ZIP code	County	Medical record number	Current plan	Transfer effective date (see above)

3 CONTACT INFORMATION

Email completed form to the Account Management Team: **amt@kp.org**.