KAISER PERMANENTE®

Small Business
CENSUS

INSTRUCTIONS

For a no-obligation rate quote, complete the form below and email to **kaiser.sbu.sales@kp.org**. Please list all employees who are eligible for health care benefits.

COMPANY INFORMATION

Company name

Street address (no P.O. boxes)

City	State	ZIP	County

Office phone ( ) –	Ext.	Fax ( ) –

Number of employees who are eligible for health coverage	Current carrier

BROKER INFORMATION

Firm name	Kaiser Permanente firm ID
Agent name	Agency license #

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

Street address	City	State	ZIP

STRATEGY (OPTIONAL)

☐ Sole Carrier ☐ Slice ☐ Multiple Plan Offering ☐ Account-Based Plans ☐ Workforce Health

EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION*

List all employees, owners, and dependents you'd like quoted. A dependent is a spouse, domestic partner, child or domestic partner's child. Use additional page, as needed.

*For each employee/dependent listed, all fields must be filled out completely to process this form.

First name	Last name or initial	Date of birth (mm/dd/yyyy) or age	Home ZIP	Relationship (check one)		
				☐ Employee/owner	☐ Spouse	☐ Child
				☐ Employee/owner	☐ Spouse	☐ Child
				☐ Employee/owner	☐ Spouse	☐ Child
				☐ Employee/owner	☐ Spouse	☐ Child

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CONTACT INFORMATION

For more information, please contact Kaiser Permanente at **800-789-4661**, option 2.

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EMPLOYEE/DEPENDENT ELIGIBILITY INFORMATION* *(continued from page 1)*

Company name

*For each employee/dependent listed, all fields must be filled out completely to process this form.

First name	Last name or initial	Date of birth (mm/dd/yyyy) or age	Home ZIP	Relationship (check one)
				☐ Employee/owner ☐ Spouse ☐ Child
				☐ Employee/owner ☐ Spouse ☐ Child
				☐ Employee/owner ☐ Spouse ☐ Child
				☐ Employee/owner ☐ Spouse ☐ Child
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