KAISER PERMANENTE®

California Small Group

BROKER OF RECORD AUTHORIZATION

(Existing Group)

Completing this form will prompt a broker of record change which will terminate any existing broker relationship and replace them with the broker selected below.

Email this completed form to **amt@kp.org** or fax this form to **800-369-8010.**

If you have any questions, contact our Small Group Account Management Support Team at **800-790-4661, option 3.**

1 COMPANY INFORMATION

Company name	Group number
Contact name	Contact title
Contact address	Contact phone number ( ) -
Contact email	

2 AUTHORIZED CONTRACT SIGNER INFORMATION (if different from above)

Contract signer name	Contract signer phone number ( ) -
Contract signer email	

3 AGENT/BROKER INFORMATION

Effective date of new agent/broker

Agent/Broker name		License number	
Firm name		Kaiser Permanente broker firm ID	
Firm address	City	State	ZIP code

4 AGENT/BROKER AUTHORIZATION

By submitting and signing this request:

- I, for the undersigned group, hereby request to designate the agent/broker named above as our authorized agent/broker for Kaiser Foundation Health Plans.
- I authorize our designated agent/broker to complete, sign and submit forms on behalf of the group without the need for a signature from the group. I agree to be bound by transactions performed by the agent/broker on our behalf. This includes our agent/broker submitting an *Employer Application* form to contract with Kaiser Permanente for Small Group health care coverage.
- I authorize you to discuss and provide group specific information to our designated agent/broker. This information includes, but not limited to, our group plan agreement, rates, benefit, payment information and, to the extent permitted by applicable law, protected health information (PHI).

5 CALIFORNIA FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a health plan or an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance benefits, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the state's regulatory agency.

6 CONTRACTING AGREEMENT AND SIGNATURE

This form needs to be dated the 1st of the month and received within the first 5 business days of the month to be effective the 1st of the current month. If received after the 5th business day of the month, BOR relationships can be effective on day of receipt, with the Payee effective the 1st day of the following month. If this form is dated after the 1st of the current month, BOR relationships can be effective on day of receipt, with payee effective the 1st day of the following month.

Only fully appointed Kaiser Permanente agents/brokers are entitled to receive commissions in conjunction with the placement, installation and/or servicing of our insurance contract/agreement.

If my authorized agent/broker submits an *Employer Application* for Kaiser Permanente Small Group coverage, as a company principal/corporate officer, having authority to contract with KFHP and KPIC, 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.
- The eligibility data provided by my company to Kaiser Permanente will include coverage effective dates for my company's employees that correctly account for eligibility in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents will be on the 1st of the month and won't exceed the waiting period established by my company.
- My company will abide by the contract provisions.

I have 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 attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I have a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) and I will comply with the health plan's participation requirement.

I attest that my company isn't participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage.

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 have 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.

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.

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 cannot 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 contract signer (please print name)	Company title (please print)
Signature X	Date

**Disputes arising from the following fully insured Kaiser Permanente Insurance Company (KPIC) coverages aren't subject to binding arbitration: 1) the Participating and Non-Participating Provider Tiers of the Point-of-Service (POS) plans; 2) PPO plans; 3) OOA plans; and 4) KPIC Dental plans.*