Kaiser Permanente Insurance Company (KPIC)
Field Underwriting Questionnaire

The following questionnaire must be completed when offering Added Choice POS-3, Dual Choice PPO or Out-of-Area coverage options to a prospective purchaser that Kaiser classifies as a "Large Group" in California. To meet Kaiser's classification as a "Large Group", the employer must have 51 or more employees working full-time (at least 20 hours per week) who are offered employer-sponsored health coverage.

Employer Group Legal Name: _____ Fed Tax ID#: _____ SIC:

Section A. Prequalifying a Prospective Purchaser

Please ask the purchaser to respond to the following questions and mark their response below.

		Yes	No
1.	Has the group offered health coverage for at least one year?	☐	☐
2.	Do 70% of the eligible employees participate in an employer-sponsored group health plan?	☐	☐
3.	Will the group contribute at least 50% of the employee-only rate for the plan (HMO, POS, PPO, OOA) in which the subscriber is enrolled? (100% if it is a one-step rate).	☐	☐
4.	Do 75% of all employees in California who will be offered a Kaiser product reside in the Kaiser Permanente California Service Area?	☐	☐
5.	Will the estimated initial enrollment in the POS, PPO, and OOA products be less than 35% of the total enrollment in Kaiser?	☐	☐
6.	How many carriers has this group had in the last 3 years? _____ If this number is less than 3, check yes.	☐	☐
7.	If the group has 150 or fewer employees, will Kaiser be the sole health carrier?	☐	☐
8.	If the group has 151 or more employees, and another carrier is offered, will Kaiser coverage be treated comparably, regarding access for enrollment, equal employer contribution, equal benefit offering, equal waiting period, freezing or limiting enrollment?	☐	☐
9.	Will there be at least 3 POS, PPO, or OOA subscribers? If not, will all of those who are offered KPIC enroll in KPIC?"	☐	☐
10.	Will the combined KFHP/KPIC enrollment be less than 10% for COBRA and non-Medicare retirees?	☐	☐

A "no" response to any of the questions above will make the prospective purchaser ineligible for a quote **Do Not** complete Sections B and C below.

Section B. Medical Profile

Please complete the following section and attach any additional sheets or documentation as needed.

		Yes	No
1.	To the best of your knowledge, how many employees or dependents are presently hospitalized or disabled? _____. What is the diagnosis and prognosis of these individuals? (List on a separate sheet.)		
2.	Will current carrier extend benefits to those disabled upon this transfer of coverage?	☐	☐
3.	How many employees, dependents or COBRA participants had any individual claims in the last 12 months in excess of $10,000? _____ What is the diagnosis and prognosis of these individuals? (List information on a separate sheet and indicate which individuals are COBRA.)		
4.	Is anyone apt to have a continuing claim from an existing mental or physical disorder? What is the diagnosis and prognosis of these individuals? (List on a separate sheet.)	☐	☐
5.	Has anyone been advised to have surgery in the last 12 months or anticipate hospitalization for any other reason (i.e., organ transplant, chemo therapy, kidney dialysis, etc. . .)? What is the diagnosis and prognosis of these individuals? (List on a separate sheet.)	☐	☐
6.	Are there ongoing HMO or indemnity claims? If yes, please attach explanation on a separate sheet.	☐	☐
7.	How many employees or dependents are pregnant?		

Section C. Purchaser Data

Please submit the census information requested below and for all groups with 50 or more indemnity subscribers two years of monthly paid claims and premiums. If the group's current coverage is self-funded, three years of monthly paid claims and premiums is required.

The census must contain the age, sex, family status and zip code of the eligible employees. If the group currently offers multiple indemnity plans, the census should also contain an indicator of who is enrolled in the HMO and who is enrolled in the indemnity product. A copy of a recent billing statement is an acceptable substitute for the indicator on the census.

Please complete the following section and attach any additional sheets or documentation as needed

		Yes	No
1.	How many years have they been in business? _____ years		
2.	Do they provide worker's compensation coverage for their employees?	☐	☐
3.	Is this a statewide employer? If yes, will they offer Kaiser in both the Northern and Southern California divisions?	☐ ☐	☐ ☐
4.	Is this a brokered group? Is this the broker of record? Yes ☐ No ☐	☐	☐
1.	Will Kaiser be the exclusive carrier for this group? If no, who is the other carrier? What is the expected Kaiser penetration? _____%	☐	☐
6.	Have the employees of this group been offered Kaiser in the last two years?	☐	☐
7.	Are the employees breaking away from a union or association? If yes, please attach explanation on a separate sheet.	☐	☐
8.	What is the total number of employees eligible for health coverage with this company?		
9.	How many are currently participating in the employer sponsored health plan?		
10.	How many will be offered Kaiser?		
11.	Does this census represent all full-time, eligible employees who will be offered Kaiser? If no, please attach explanation on a separate sheet.	☐	☐
12.	How many are currently on family medical leave? Be sure to include these employees on the census.		
13.	Are there employees who are waiving coverage or in a waiting period who are not listed here? If yes, please attach explanation on a separate sheet. Be sure to include these employees on the census.	☐	☐
14.	Are there any special waiting periods for enrollment? If yes, please attach explanation on a separate sheet?	☐	☐
1.	How many COBRA or state continuation eligibles? _____ Be sure to include these employees on the census and COBRA effective dates.	☐	☐
16.	How many retirees? _____ Be sure to include these employees on the census. How many are non-Medicare retirees? Be sure to include these employees on the census.	☐ ☐	☐ ☐
17.	How many of the employees who will be offered Kaiser resides outside of Kaiser's California Service Area?		
18.	Who is the current carrier and how long has the employer had that carrier? _____ _____ years		
19.	Provide a description of the current carrier plan (HMO, POS, PPO) and the benefits offered for each, the current and renewal rates and the employer contribution for employees and dependants. Attach additional sheets as necessary.		

I understand and agree, on behalf of the purchaser, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers will become part of: (a) any Service Agreement issued by KFHP, (b) any policy or policies, which may ultimately be issued by KPIC; and are made to induce KPIC and/or KFHP to issue group coverage.

_____	_____	_____/_____/_____
Employer Signature	Title	Date
_____	_____	_____/_____/_____
Kaiser Representative	Title	Date