Employer Group Application

LARGE GROUP SALES

KAISER PERMANENTE®

Please complete all sections of this form, except that information that is required to obtain Kaiser Permanente Insurance Company (KPIC) is not applicable if you are not applying for coverage offered by KPIC.

All coverage is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) except for the following:

Kaiser Permanente Insurance Company KPIC underwrites (1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; (2) Preferred Provider Organization (PPO) plans; (3) Out of Area Indemnity (OOA) plans; and (4) KPIC Dental plans.

Delta Dental Plan of California underwrites DeltaCare/PMI.

EMPLOYER GROUP INFORMATION

APPLICATION is hereby made for group health coverage based on the following statements and representations:

GROUP LEGAL NAME (as it should appear on contract) _____ GROUP DBA NAME (if applicable) _____ CUSTOMER OR PURCHASER ID _____

ADDRESS FOR MAILING CONTRACTS (EMPLOYER HEADQUARTERS ADDRESS)

☐ Send Coordination of Benefits (COB) information here (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street _____ City _____ State _____ ZIP _____

Attention: _____ Title _____

Phone _____ Fax _____ Email _____

LOCAL CONTACT *(if different from "contracts" address above)*

☐ Send Coordination of Benefits (COB) information here (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street _____ City _____ State _____ ZIP _____

Attention: _____ Title _____

Phone _____ Fax _____ Email _____

BILLING CONTACT *(if different from "contracts" address above)*

☐ Send Coordination of Benefits (COB) information here (This address will be used in association with the TIN/EIN listed below in reporting MSP data to CMS.)

Street _____ City _____ State _____ ZIP _____

Attention: _____ Title _____

Phone _____ Fax _____ Email _____

(If more than one billing location, please attach information for each location.)

ENROLLMENT INFORMATION

Nature of business _____ Years in business _____

FEDERAL TAX ID # (TIN)/EIN _____ SIC Code _____

Are all eligible employees in your group associated with the same TIN/EIN? ☐ Yes ☐ No

Total # of employees _____ # of eligible employees _____

Group size—please select the appropriate category:

☐ 20–99 full- and/or part-time employees for 20 or more weeks of the current or prior calendar year

☐ 100+ full- and/or part-time employees for 50 percent or more of your regular business days during the prior calendar year

Requested date of contract: Month _____ Year _____

(If requesting an anniversary date other than the usual 12-month period from the effective date, please indicate reason for request.)

Annual open enrollment period: Enroll during the month of _____ For coverage effective _____ 1st

Will the group contribute at least 50% of the employee-only rate for the plan (HMO, POS, PPO, OOA) in which the employee is enrolled? (100% if it is a one-step rate.) ☐ Yes ☐ No

How much will the employer contribute to the cost of the employees', dependents', and retirees' (if any) health plan?

Employee (and early retiree) $ or % _____ Dependent $ or % _____ Retiree with Medicare $ or % _____

What is the contribution level to the HRA and/or HSA account, if applicable? _____% or $_____

Has Kaiser Permanente coverage been offered to your employees within the past 24 months? ☐ Yes ☐ No

Type of plan sponsor: ☐ Employer ☐ Labor organization ☐ Trustees of a fund

Type of company: ☐ State government ☐ Local government ☐ Publicly traded corporation ☐ Privately held corporation ☐ Nonprofit ☐ Church group ☐ Other

Mark any that apply: ☐ Taft-Hartley ☐ Hours Bank ☐ Multi-employer/multiple employer group

RATE ASSUMPTIONS

1. Has the group offered health coverage for at least one year? ☐ Yes ☐ No
2. Do 75% of the eligible employees participate in an employer-sponsored group health plan? ☐ Yes ☐ No
3. Do 75% of all employees in California who will be offered a Kaiser Permanente product reside in the Kaiser Permanente California service area? ☐ Yes ☐ No
4. Will the estimated initial enrollment in the PPO and OOA products be less than 25% of the total enrollment in Kaiser Permanente? ☐ Yes ☐ No
5. Will Kaiser Permanente be offered to all eligible employees? ☐ Yes ☐ No
   If no, why not? _____
6. How many carriers has this group had in the last 3 years? _____ If less than 3, check here ☐
   If 3 or more, why? _____
   _____
7. Will Kaiser Permanente be offered on terms less favorable than any other carrier or plan available to the group's employees? ☐ Yes ☐ No

MEDICAL PROFILE

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 the current carrier extend benefits to those disabled upon this transfer of coverage? ☐ Yes ☐ No
3. How many employees, dependents, or COBRA participants had any individual claims in the last 12 months in excess of $10,000? _____
   (List on a separate sheet and indicate which individuals are COBRA participants.)
4. Is anyone likely to have a continuing claim from an existing mental or physical disorder? ☐ Yes ☐ No
   If yes, what is the diagnosis and prognosis of these individuals? (List on 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, chemotherapy, kidney dialysis, etc.)? If yes, what is the diagnosis and prognosis of these individuals? (List on a separate sheet.) ☐ Yes ☐ No
6. Are there ongoing HMO or indemnity claims? ☐ Yes ☐ No
   If yes, please attach explanation on a separate sheet.
7. How many employees or dependents are pregnant? _____

EMPLOYER DATA

1. Do you meet CA state law requirement for providing employees worker compensation coverage? ☐ Yes ☐ No
2. Is Kaiser Permanente the exclusive carrier for this group? ☐ Yes ☐ No
   If yes, will Kaiser Permanente remain the exclusive carrier for the entire contract period? ☐ Yes ☐ No
   If no, who is the other carrier? _____
3. Does this census represent all permanent, eligible employees? ☐ Yes ☐ No
4. Do you have employees currently on family medical leave or leave of absence? ☐ Yes ☐ No
   If yes, were they included on the census? ☐ Yes ☐ No
5. Are there any special waiting periods for enrollment? ☐ Yes ☐ No
   If yes, were these employees and their effective date(s) included on the census? ☐ Yes ☐ No
   If not included, please add on separate sheet.
6. How many are retirees with Medicare? _____ How many are early retirees? _____
   Were they identified on the census? ☐ Yes ☐ No
7. How many are COBRA participants? _____
   Were they identified on the census? ☐ Yes ☐ No

CARRIER NAME(S)	KAISER PERMANENTE Plan 1*					ALTERNATIVE CARRIER PLANS Carrier name:				ALTERNATIVE CARRIER PLANS Carrier name:			
PRODUCT TYPE(S)*	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 5**	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
HRA paired with													
HSA-Qualified (✓ for Yes)													
RATES													
Employee Only	$	$	$	$	$	$	$	$	$	$	$	$	$
Employee + Spouse	$	$	$	$	$	$	$	$	$	$	$	$	$
Employee + Child(ren)	$	$	$	$	$	$	$	$	$	$	$	$	$
Family	$	$	$	$	$	$	$	$	$	$	$	$	$
BENEFITS													
Plan Deductible													
Plan Out-of-Pocket Maximum													
Coinsurance													
Physician Office Visits													
Prescriptions													
Optical													
Chiropractic/Acupuncture													
Hospital													
Emergency													
ELIGIBILITY													
Plan Participation Minimum													
Student Coverage Age Limit													

DENTAL

Delta Dental Plans: ☐ FFS Plan _____ ☐ PPO Plan _____

Which health care plan will the dental plan be offered with? ☐ HMO ☐ PPO ☐ Deductible HMO ☐ POS ☐ Stand-alone dental (dental only)

Monthly Dental Rates: ☐ Employee Only $ _____ ☐ Employee + Spouse $ _____ ☐ Employee + Child(ren) $ _____ ☐ Employee + Spouse + Child(ren) $ _____

DeltaCare/PMI: Which health care plan will the dental plan be offered alongside of? ☐ HMO ☐ Deductible HMO ☐ POS

Monthly Dental Rates: ☐ Employee Only $ _____ ☐ Employee + Spouse $ _____ ☐ Employee + Child(ren) $ _____ ☐ Employee + Spouse + Child(ren) $ _____

*** All coverage is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) except for the following:**

- **Kaiser Permanente Insurance Company (KPIC) underwrites (1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; (2) Preferred Provider Organization (PPO) plans; (3) Out of Area Indemnity (OOA) plans; and (4) KPIC Dental plans.**
- **Delta Dental Plan of California underwrites DeltaCare/PMI**

COBRA BILLING

Section 125 Plan: ☐ Currently in place ☐ Not applicable
COBRA billing: ☐ Performed by employer ☐ Performed by TPA†

†TPA name TPA address TPA phone

ERISA STATUS

Is your group's health plan subject to the Employee Retirement Income Security Act (ERISA)? ☐ Yes ☐ No

(If you do not select an answer, we will record the status as Yes)

CONTRACT DELIVERY

We will deliver your KFHP health plan/KPIC health insurance contracts on our website unless you indicate below that you want your contract(s) delivered by mail:

☐ I want to receive my contracts by mail in paper format

RELIGIOUS EMPLOYER ATTESTATION *(must be completed if your Group wants to exclude coverage for contraceptives)*

I attest that Group meets all of the requirements for the religious employer exemption from the California requirement to cover contraceptive services, because it meets all of the following requirements:

- The inculcation of religious values is the purpose of the entity.
- The entity primarily employs people who share the religious tenets of the entity.
- The entity serves primarily people who share the religious tenets of the entity.
- The entity is a nonprofit organization as described in Internal Revenue Code sections 6033(a)(3)(A)(i) or (iii).

Group will indemnify and hold harmless Kaiser Foundation Health Plan, Inc. (Health Plan) and/or Kaiser Permanente Insurance Company (KPIC)* and its agents, officers, and employees acting in their capacity as agents of Health Plan and/or KPIC against any claims, actions, fines, costs (including reasonable attorneys' fees), damages, or judgments, to the extent that they arise out of not covering contraceptive services in reliance on this Religious Employer Exemption Attestation.

* All coverage is underwritten by KFHP except for the following: KPIC underwrites (1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; (2) Preferred Provider Organization (PPO) plans; (3) Out of Area Indemnity (OOA) plans.

Signature of Group's authorized officer: _____ Date:

Name and title:

BROKER OF RECORD INFORMATION *(as shown on payee's license)*

Broker Name _____ Broker Firm Name _____

Street _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

CA A&D License # _____ Expiration Date _____

Payee Social Security # _____ Payee Federal Tax ID # _____

Authorized Signatory for Broker Firm _____

Kaiser Permanente Individual Broker ID # _____ Kaiser Permanente Broker Firm ID # _____

Payee Address _____

(if different from the address you listed on page 1)

Notice to broker: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

Broker Signature _____ Date:

CONDITIONS OF ACCEPTANCE

I understand that the rates quoted herein are not final until (1) Kaiser Foundation Health Plan, Inc. (KFHP), and/or Kaiser Permanente Insurance Company (KPIC) receive a signed copy of this Employer Group application, and (2) KFHP and/or KPIC have verified the conditions of offering and accuracy of the underwriting information and completed its review. I understand that KFHP and/or KPIC must receive this application before the effective date of coverage. I understand that KFHP and/or KPIC reserve the right to withdraw our rate proposal or re-rate any proposed rates if any of the information in this application is incomplete or inaccurate, or if the information provided in the "Rate Assumptions" section of this application is incorrect or materially false.

I authorize the person named in the "Broker of Record" section to act as broker of record for our health plan coverage through KFHP and KPIC effective _____, 20__. I understand that the broker of record will be paid commissions and may be eligible for monetary and nonmonetary rewards and incentives by KFHP and/or KPIC in connection with this purchase of health plan coverage.

I represent that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations ("ACA"). Also, I represent that eligibility data provided by Group to KFHP or KPIC will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the ACA. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

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 may be terminated, any coverage by KPIC may be rescinded, or the applicable premiums/rates may be adjusted.

I understand that if KFHP intends to terminate my coverage, I will be sent a notice via regular certified mail at least 30 days prior to the effective date of the termination explaining the reasons for the intended termination and notifying me of my right to appeal that decision to the Department of Managed Health Care.

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

KAISER FOUNDATION HEALTH PLAN BINDING ARBITRATION AGREEMENT*

As more fully set forth in the arbitration provision in *Evidence of Coverage* documents that are part of *Group Agreement*s between Kaiser Foundation Health Plan, Inc., (KFHP) and groups, disputes between members, their heirs, relatives, or associated parties (on the one hand) and KFHP, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to the *Group Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items 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 pursuant to the *Group Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under the *Group Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- Claims that cannot be subject to binding arbitration under governing law

**Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: (1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; (2) Preferred Provider Organization (PPO) plans; (3) Out of Area Indemnity (OOA) plans; and (4) KPIC Dental plans.*

Name _____ **Title** _____

Signature _____ **Date** _____