KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Level Funded Application

Please complete fully, sign and return to your Kaiser Permanente representative. Any missing information may cause a delay.

Requested effective date: _____

1. ABOUT YOUR BUSINESS

_____
Full Legal Business Name (write on line above)

_____
Doing Business As (DBA)

_____ _____ _____ _____
Physical Address | City | State | ZIP code

_____ _____ _____ _____
Mailing Address if Different Than Physical Address | City | State | ZIP code

_____ _____
Nature of Business (please be specific) | Phone Number

_____ _____ _____ _____
Years in Business | Federal Tax ID Number (EIN/TIN) | NAICS Code (6 digits) | Renewal Date

_____ _____
Open Enrollment Start Date | Open Enrollment End Date

Type of Business

☐ Corporation ☐ Labor-Union ☐ Partnership ☐ Limited liability company (LLC)

☐ Sole Proprietorship ☐ Other (fill in type) _____

Are you subject to ERISA? ☐ Yes ☐ No

If No, select reason for exemption: ☐ Gov't Entity ☐ Religious Purchaser ☐ Other

Is employer an eligible organization under the Patient Protection and Affordable Care Act or a Religious Purchaser?

☐ Yes ☐ No

If so, does employer want to exclude contraceptive coverage? ☐ Yes ☐ No

Please provide names and locations (street address, city, state, postal code) for any affiliates and subsidiaries covered within the plan:

2. ENROLLMENT INFORMATION

In determining the number of employees or eligible employees, affiliated companies that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer and must apply as one employer. If your company is affiliated with another company, is your company eligible to file a combined tax return?

☐ Yes ☐ No

Please provide the total number of eligible employees:* _____

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

If no, please specify employees names and corresponding TIN/EIN _____

Eligible full-time employees must work at least 20 hours per week to qualify for coverage.
Eligible part-time employees must work less than 20 hours per week to qualify for coverage.

Number of enrolled employees: _____ Number of employees waiving coverage: _____

Number of full-time employees: _____ Number of part-time employees: _____

Total number of COBRA Participants: _____
Please attach COBRA coverage and end dates.

Describe any applicable employee classifications:_____

Waiting period (cannot exceed 90 days)/When coverage begins. Please describe:

_____

Do you have employees currently on family medical leave or leave of absence? ☐ Yes ☐ No

If yes, please provide the name and expected return to work date for each person. Add a separate document if needed and include with this application.

Rehire/When coverage begins. Please describe: _____

Termination policy – Coverage until the end of month.

Will you offer dependent coverage?** ☐ Yes ☐ No Will you offer coverage to domestic partners? ☐ Yes ☐ No

If Dependent Children can enroll, then Dependent Children are covered until the end of the month in which they become 26.

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* If your total number of employees noted above is more than 100, please provide the total number of full-time and full-time-equivalent employees. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to your legal counsel. To qualify for Kaiser Permanente Level Funded, your company must have at least one but no more than 100 full-time and full-time-equivalent employees.

** Please contact your advisor for information regarding your Employer Shared Responsibility as a plan sponsor under the Affordable Care Act (ACA). See section 4980(H)(C)(2) of the Internal Revenue Code.

3. OTHER MEDICAL OFFERINGS

Does your company or affiliated company(ies) have, or has it ever had, group coverage directly through Kaiser Permanente? ☐ Yes ☐ No

If Yes, please provide the group ID and company name.

Group ID _____ Company Name _____

Does your company currently have active health coverage? ☐ Yes ☐ No

If Yes, Name of Carrier _____ Renewal Date _____ Carrier Phone Number _____

Kaiser Permanente Level Funded program must be offered as sole health option to all eligible employees.

Please confirm other coverage in the last three years not disclosed above: ☐ Yes ☐ No

If Yes, Name of Prior Carrier _____ Prior Coverage Start Date _____ Prior Coverage End Date _____

If Yes, Name of Prior Carrier _____ Prior Coverage Start Date _____ Prior Coverage End Date _____

4. WORKERS' COMPENSATION

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible for Level Funded if you don't have workers' compensation unless you're exempt.

I attest that the following information is correct.

☐ Yes, my company has workers' compensation ☐ Pending

If Yes or Pending, name of carrier:_____ and Policy #: _____

If exempt from providing workers' compensation, list reason: _____

5. SURPLUS OPTION

Select surplus option: ☐ 50% ☐ 67%

6. PLANS / BENEFITS SELECTED

Please check the plan(s) selected below. Select up to three standard plans, plus up to two OOA/POS plans. For more information on the plans listed below, contact your sales representative or agent/broker.

EPO	☐ KPLF 0/15/3000 ☐ KPLF 0/40/6000	☐ KPLF 0/30/4500
Deductible EPO	☐ KPLF 250/10%/3000 ☐ KPLF 1000/15%/3500 ☐ KPLF 2000/20%/4500 ☐ KPLF 3000/25%/6000 ☐ KPLF 5000/30%/8000 ☐ KPLF Everyday Care 8000/0%/8000	☐ KPLF 500/10%/3000 ☐ KPLF 1500/15%/4000 ☐ KPLF 2500/20%/5000 ☐ KPLF 4000/25%/7000 ☐ KPLF 6000/30%/9000
HDHP	☐ KPLF HDHP 2000/20%/4000 ☐ KPLF HDHP 4000/30%/7000 ☐ KPLF HDHP 5000/40%/7000	☐ KPLF HDHP 3500/20%/6500 ☐ KPLF HDHP 5000/0%/5000
PLUS - EPO	☐ KPLF PLUS 0/15/3000 ☐ KPLF PLUS 0/40/6000	☐ KPLF PLUS 0/30/4500
PLUS - DEPO	☐ KPLF PLUS 250/10%/3000 ☐ KPLF PLUS 1000/15%/3500 ☐ KPLF PLUS 2000/20%/4500 ☐ KPLF PLUS 3000/25%/6000 ☐ KPLF PLUS 5000/30%/8000	☐ KPLF PLUS 500/10%/3000 ☐ KPLF PLUS 1500/15%/4000 ☐ KPLF PLUS 2500/20%/5000 ☐ KPLF PLUS 4000/25%/7000 ☐ KPLF PLUS 6000/30%/9000
PLUS – HDHP	☐ KPLF PLUS 2000/20%/4000 ☐ KPLF PLUS 4000/30%/7000	☐ KPLF PLUS 3500/20%/6500 ☐ KPLF PLUS 5000/40%/7000
POS (In-service area)	☐ KPLF POS 500/10%/3000 ☐ KPLF POS 3000/30%/5000	☐ KPLF POS 1500/20%/4000 ☐ KPLF POS 5000/30%/7000
POS HDHP (In-service area)	☐ KPLF POS HDHP 3500/30%/5000	☐ KPLF POS HDHP 5000/30%/6500
OOA PPO (Out-of-service area)	☐ KPLF PPO 2000/25%/7500 ☐ KPLF PPO 7000/40%/9000	☐ KPLF PPO 3500/35%/9000 ☐ KPLF PPO 5000/40%/9000
OOA PPO HDHP (Out-of-service area)	☐ KPLF PPO HDHP 5500/40%/7000	
Custom Benefit Plan	☐ Check here if custom plan Insert plan name_____ Insert plan name_____	

6. PLANS / BENEFITS SELECTED, CONTINUED

Does the Plan exclude Voluntary Termination of Pregnancy?	☐ Yes	☐ No
Do you want to add KP Health Payment Account?	☐ Yes	☐ No
If yes, which KP Health Payment Account(s) are you choosing:	**Health savings account (HSA)**	☐ HSA with a card
	Health reimbursement arrangement (HRA)	☐ HRA 213(d) with a card ☐ HRA Health plan-only with automatic reimbursement ☐ HRA Deductible-only with automatic reimbursement
	Flexible spending account (FSA)	☐ Medical FSA ☐ Dependent care FSA ☐ Limited-purpose FSA (must be paired with an HSA)
Employer Contributions	Employer contribution percentage is_____for employees and_____for dependents.	
LEGAL AND ADMINISTRATIVE INFORMATION		
Please provide the following information for the plan. This information will be reflected in your Summary Plan Description benefit booklet.	Plan Name (As Provided to the Department of Labor on the Form 5500):	
	ID Number (ERISA Plan Number):	
	Plan Administrator (Name & Address):	
	Service of Legal Process (Name & Address):	

7. MEDICARE

Prior calendar year average total number of employees _____

Is your Plan primary?* ☐ Yes (20 employees or more) ☐ No (less than 20 employees)

* Under federal law, if your company had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Plan is primary and Medicare is secondary. This statement does not set forth all rules governing Medicare status. You should contact your legal counsel for information regarding other rules that may impact your company's Medicare status.

8. PLAN CONTACTS

Plan Administrator

This principal person is responsible for signing the Administrative Services Only agreement, providing renewal information, and is authorized to make enrollment or contractual changes.

Name (write on line above)

Title

Administrator Mailing Address (if different than Physical Address)

Administrator Phone

Administrator Email Address

Designate Additional Contacts if Needed:

Banking

Name

Title

Phone

Email Address

Billing

Name

Title

Phone

Email Address

COBRA

Name

Title

Phone

Email Address

TPA/COBRA

TPA Name

TPA Contact Name

TPA Phone

TPA Contact Email Address

Will the TPA be administering Federal COBRA? ☐ Yes ☐ No

Reporting

Name

Title

Phone

Email Address

9. PLAN PHI RECIPIENT(S)

#1 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

#2 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

#3 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

NOTE: Only designated recipients are eligible to receive reports from Kaiser Permanente containing PHI, access to the website, and/or receive information when calling customer service on behalf of the employee and their dependent(s). Multiple designees are acceptable. If you have additional PHI recipients, please fill out the PHI Recipient List.

10. NOTICE CONTACTS

The contracting Plan Sponsor must designate one or more persons to receive and be legally responsible for any official notices that are sent out regarding the Plan Sponsor's rights or obligations under the contract, during the term of the contract. The Plan Sponsor will be legally assumed to know all the information sent to the Notice Contact. **You must provide at least one Notice Contact; any additional Notice Contact is dependent on Plan Sponsor's requirements. You can provide a title only.**

Notice Contact 1 (required)

Notice Contact Name

Notice Contact Title

Notice Contact Department

Notice Contact Address

City

State

ZIP code

Notice Contact 2 (optional)

Notice Contact Name

Notice Contact Title

Notice Contact Department

Notice Contact Address

City

State

ZIP code

11. BROKER OF RECORD / BROKER COMPENSATION / GENERAL AGENCY

AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE To be completed by your Kaiser Permanente appointed agent/broker after completion of this application. Your broker will have the same access to your account as the plan sponsor, with the exception that a broker can't sign this Employer Application.

If you're a broker who hasn't registered as a firm or agent with Kaiser Permanente or if any information has changed, please contact your Kaiser Permanente representative.

Notice to agent or broker: you must select 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

Licensed Broker Representative Name

License Number

Firm Name

KP Broker Firm ID

Broker Phone Number

Broker Email Address

Broker Mailing Address

Did you agree to a non-standard broker commissions amount? If yes, what amount was agreed upon?_____

Agent/Broker Signature

General Agency

Today's Date

12. IMPORTANT INFORMATION

1. Kaiser Permanente Insurance Company (KPIC) will not agree to provide any administrative services (including the preparation of a Benefit Booklet) or issue stop loss coverage until it has completed its review of the information in this document and executed an agreement with the plan sponsor. Groups may be subject to a recertification process to verify the accuracy of the information provided by the group.
2. I certify, to the best of my knowledge, that all the responses given are true, correct, and complete.
3. Level Funded is not an insurance product. Level Funded is a self-funded plan administered by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. Self-funded plans require a contract between KPIC and the plan sponsor (employer). KPIC will act as the administrator.
4. Section 1557 of the ACA: Certain employer group plans, entities, and employers are subject to Section 1557, which generally prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. All group plans, entities, and employers should carefully review all requirements with their legal counsel.

13. AUTHORIZED CUSTOMER SIGNER

Plan Sponsor Authorized Representative (please print)

Signature of Plan Sponsor Authorized Representative

Title (please print)

Today's Date