KAISER PERMANENTE®

Colorado Small Group
EMPLOYER APPLICATION

CONNECT for HEALTH COLORADO®

Please complete all information.
We can't process incomplete applications.

Requested effective date ____/____/____

1 ABOUT BUSINESS

Legal business name (as stated on your local business license, quarterly wage and tax report, corporate or partnership documents)	Doing business as (DBA)

Physical street address **(no P.O. boxes)**	City	State	ZIP	County

Phone ( ) –	Business website

Type of business ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since (mm/dd/yyyy) / /	Federal tax ID (EIN) number	SIC code (4 digits)	NAICS code (6 digits - visit **naics.com/search**)

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage 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: _____ Policy # _____
(indicate *unknown* or *pending* as applicable)

☐ Exempt from providing workers' compensation for the following reason: _____

2 OTHER MEDICAL COVERAGE

Does your company or affiliated company(ies) have or has it ever had group coverage directly through Kaiser Permanente? If *Yes*, please provide the group number and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal month:

Will you be offering another carrier or alternative coverage, alongside Kaiser Permanente, to your employees? ☐ Yes ☐ No

Name of carrier or type of alternative coverage: Renewal month: Number of employees enrolled:

If offering alternative coverage that is not an ACA small group plan, please explain:

3A EMPLOYER ELIGIBILITY

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.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No If *Yes*, please provide below:

Company name	☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal tax ID number	Phone ( ) –

3B EMPLOYEE COUNT

Please provide the total number of employees nationwide **(full-time and part-time).**

Total _____

Note: If the total number of employees noted above is 100 or fewer, skip the following and go to section 3C.
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** on the line below. To qualify for small group coverage, your company must have at least one but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to your legal counsel.

Total _____

Business name (please print): _____

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible employees.** Total _____

Please provide the total number of **enrolling employees.** Total _____

Hours per week employees must work to be eligible for coverage: _____

Are you offering dependent coverage?[1] ☐ Yes ☐ No

Do you wish to provide coverage for designated beneficiaries as dependents? ☐ Yes ☐ No

[1]If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980(H)(C)(2) of the Internal Revenue Code.

3D DOMESTIC PARTNER COVERAGE

Do you wish to offer non-state registered Domestic Partner Coverage? ☐ Yes ☐ No

If *Yes*: ☐ Same Sex Domestic Partner Only
☐ Opposite Sex Domestic Partner Only
☐ Same and Opposite Sex Domestic Partner

See Domestic Partner Coverage in the Agreement and Signature section for state registered and non-state registered domestic partner coverage details.

4 CONTINUATION COVERAGE

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA? ☐ Yes ☐ No

Are you submitting COBRA applications? ☐ Yes ☐ No

5A ERISA STATUS

Is your company subject to ERISA? ☐ Yes ☐ No If you do not select an answer, we will record your status as *Yes*.

ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally are not. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

5B MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA? ☐ Yes ☐ No

If your company employed 20 or more full-time and/or part-time employees for each working date for 20 or more calendar weeks in the current calendar year or preceding calendar year, your group is subject to this federal law.

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage or a fixed dollar amount.

Percentage of the premium is based on the following **(select one only):**
☐ Lowest plan offered ☐ All plans offered ☐ Specific plan offered: _____

Employer contribution: _____ % per employee _____ % per dependent **(optional)**
Employer contribution (fixed $): $ _____ per employee $ _____ per dependent **(optional)**

Business name (please print): _____

7A CONTRACT SIGNER

This person is responsible for receiving and providing renewal information and is authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title	
Mailing address		City	State	ZIP
Office phone ( ) –		Ext.	Cellphone ( ) –	
Email		How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

7B BILLING CONTACT

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information. Only one billing contact is allowed.

☐ **Check here if same as contract signer.**

First name	MI	Last name		
Mailing address		City	State	ZIP
Office phone ( ) –		Ext.	Cellphone ( ) –	
Email		How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

7C BILL DELIVERY PREFERENCE

Let us know how you prefer to receive your bills.

☐ I would like paperless bills
☐ I would like paper bills

I understand that if I do not sign up for paperless billing, Kaiser Permanente will mail a paper statement. I further understand that I can opt in or out of paperless billing at any time. A 30-day notification is required to make changes in billing notification processing. Authorized company signer's initials _____

Business name (please print): _____

8 MEDICAL PLANS

Please select the rating methodology for your group: ☐ Age-Banded rating ☐ Composite rating

PLAN INFORMATION[1]

Groups with at least 3 enrolled employees can select up to 3 plans if each of those employees is on a different plan.

HMO	☐ KP CO Platinum 0/10 RX Copay†	☐ KP CO Gold 0/20 RX Copay†	
Deductible HMO	☐ KP CO Platinum 400/10 ☐ KP CO Gold 500/25 ☐ KP CO Gold 1500/25 RX Copay†	☐ KP CO Silver 2800/45 ☐ KP CO Silver 4000/50 RX Copay† ☐ KP CO Virtual Complete Silver 6300/50 RX Copay†	☐ KP CO Bronze 7000/60 RX Copay† ☐ KP CO Virtual Complete Bronze 9450/40
Consumer Directed	☐ KP CO Gold 1750/30/HSA ☐ KP CO Silver 3200/30/HSA	☐ KP CO Silver 4400/30/HSA ☐ KP CO Bronze 6250/50/HSA	☐ KP CO Bronze 7500/100%/HSA

KP SELECT[1]

The following KP Select plans are only available to employees living in qualified locations in and around the Colorado Springs area:

HMO	☐ KP Select CO Platinum 0/10 RX Copay†	☐ KP Select CO Gold 0/20 RX Copay†	
Deductible HMO	☐ KP Select CO Platinum 400/10 ☐ KP Select CO Gold 500/25 ☐ KP Select CO Gold 1500/25 RX Copay†	☐ KP Select CO Silver 2800/45 ☐ KP Select CO Silver 4000/50 RX Copay† ☐ KP Select CO Virtual Complete Silver 6300/50 RX Copay†	☐ KP Select CO Bronze 7000/60 RX Copay† ☐ KP Select CO Virtual Complete Bronze 9450/40
Consumer Directed	☐ KP Select CO Gold 1750/30/HSA ☐ KP Select CO Silver 3200/30/HSA	☐ KP Select CO Silver 4400/30/HSA ☐ KP Select CO Bronze 6250/50/HSA	☐ KP Select CO Bronze 7500/100%/HSA

†These plans cover all prescription drugs at copay; however, many other plans also cover brand and generic drugs at copay.

Employer Groups and Insurance Carriers are required to provide the Summary of Benefits and Coverage (SBC) to plan participants and beneficiaries together with the Colorado Supplement to the Summary of Benefits and Coverage (COSSBC). Please visit **https://account.kp.org/broker-employer/resources/employer/plans/smallbusiness/summary-benefits-coverage/** to download or print your Summary of Benefits and Coverage (SBC).

[1]The Colorado Division of Insurance requires carriers to notify you of the following: This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act.

Business name (please print): _____

9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan of Colorado (KFHPCO) or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

10A AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by broker.

To the best of my knowledge and belief, employment and other information on this application is complete and accurate. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of Kaiser Foundation Health Plan, or KPIC. I've explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage, or to alter terms of the insurance.

Primary (authorized agent/broker)

Agent/broker name

Firm name	Kaiser Permanente broker firm ID
Agent/broker signature **X**	Date

10B GENERAL AGENT ACCESS

Your agent/broker may work with a General Agent (GA) to service your organization, which is a different firm from your agent/broker. The same agent/broker access to your group specific information and change permission will be granted to a designated General Agent unless you choose not to authorize access.

Do not check the box below if you consent.

☐ Check this box **ONLY** if you **DO NOT** authorize a GA to access your group specific information, service your organization, change group information, or act on your behalf.

Business name (please print): _____

11 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHPCO 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 KFHPCO 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 won't exceed the waiting period established by my company.
- My company will abide by the contract provisions.

Full Time Equivalent employees is calculated by counting the number of people who worked an average of 30 or more hours per week. Then add to this amount the number of hours worked per week by non-full time employees divided by 30. You may exclude seasonal employees that work 120 days or fewer per year.

Domestic Partner Coverage

- Coverage for state-registered (civil union) domestic partners is included in all small group plans. If children of the insured employee are covered, children of state-registered domestic partners are covered on the same basis.
- Employers may choose to provide coverage to domestic partners who are not registered with the state. If "Yes" is selected in section 3D, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

Kaiser Permanente is not advising on whether or not the law requires coverage for these individuals. Please seek guidance from your counsel on dependent coverage obligations.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I have a minimum of one W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that the minimum participation requirement of eligible employees are covered by group coverage. I agree to abide by the Kaiser Permanente deductible funding policy, which doesn't permit directly funding or reimbursing employees for any deductibles, coinsurance, or copays, except for our designated HRA plans, in accordance with the federal tax laws for HDHP/HSA plans.

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 **account.kp.org**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I understand that if I have an authorized agent/broker of record, then the agent/broker and their support staff currently on file with Kaiser Permanente will have access to my group-specific information. They're able to service my organization and to act or change group information on my behalf. Access to my account.kp.org group account will be granted to my agent/broker who can delegate authority to their support staff. This information may include, but is not limited to, renewal notices, group agreements, rates, benefits, and protected health information (PHI).

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, 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 Colorado Division of Insurance within the Department of Regulatory Agencies.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente plans **X**	Date

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 1-100 ELIGIBLE EMPLOYEES UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE CLAIMS EXPERIENCE OF OR ANY HEALTH STATUS RELATED FACTOR OF THE SMALL EMPLOYER AND ITS EMPLOYEES AND THEIR DEPENDENTS IN THE GROUP.