KAISER PERMANENTE®

Georgia

EMPLOYER GROUP MASTER APPLICATION

(FOR GROUPS 51 OR MORE ELIGIBLE EMPLOYEES)

The information requested on this application is necessary for purposes of processing your request for group coverage, and verifying the appropriateness of final rates. **Please Note:** Statements made in application form are deemed representations and are not warranties.

Effective date _____/_____/_____

1 EMPLOYER INFORMATION

Employer Legal Name	Group Contact Name	Date Prepared

DBA (if applicable)

Address	City	State	Zip Code

Phone	Fax	E-mail Address

Address of Organization's Headquarters	City	State	Zip Code

NAICS Code and SIC Code	# of Locations	Tax Id #	Coverage Effective Date

Are all of the Kaiser Permanente subscribers in your group associated with the same EIN/TIN? ☐Yes ☐No	If you do not have a federal EIN/TIN, are you a foreign-owned organization? ☐Yes ☐No

Total Number of Eligible Employees (including those waiving coverage)	Eligible Employees ☐Full-Time (hrs per week) ☐Other	Annual Renewal Date

Excluded from Eligibility ☐Retirees ☐Other

Is there a single address where all Coordination of Benefits issues and questions should be directed? ☐Yes ☐No
If yes, please provide that address (if different from address of headquarters address).

Address	Phone	Fax

City	State	Zip Code

Type of Organization (check all that apply): ☐State government ☐Publicly traded corporation ☐Church group ☐Other ☐Local government ☐Privately held corporation ☐Non-profit	Is your organization a Taft-Hartley, Hours Bank, or multi-employer organization? ☐Yes ☐No

Type of Group Plan Sponsor (check one): ☐Employer ☐Labor organization ☐Trustees of a fund established by one or more employers or labor organizations

Group Size – Total Number of Full and/or Part-time Employees (check one): Please select the largest applicable category. In making your selection, consider your organization/company's total number of employees world wide, regardless of location or eligibility for health care coverage.

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

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

2 BILLING INFORMATION

Billing Contact			☐ Same as Group Contact
Address	City	State	Zip Code
Phone	Fax	E-Mail Address	

Important Notice: The employer is responsible for determining on a monthly basis whether an individual satisfies the definition of eligible employee, as stated on the Employer Group Master Application. To be eligible, an employee must work for this employer or be on paid leave through this employer for the minimum number of full-time hours stated on this application.

3 PLAN SELECTION

For additional benefit selection information, refer to the attached plan summaries. Please review the summaries for all plans purchased and make your selections in the chart below.

Business Offering:	Plan Type Check Box:		Kaiser Permanente Multisite Plan:
☐ Sole Carrier	☐ HMO	☐ HSA-Qualified Deductible Plan	☐ Basic
☐ Slice	☐ Dual Choice PPO	☐ Deductible Plan With HRA	☐ Comprehensive
	☐ Senior Advantage*	☐ Other_____	☐ Standard
	* Certain Minimum Benefits Apply.		☐ Senior Advantage
			☐ Not Applicable

Is this coverage replacing other insurance coverage? ☐ Yes ☐ No If so, name of carrier being replaced: _____

HMO plans (including Deductible Plans) and Senior Advantage are provided by Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). The In-Network and Out-of-Network Provider benefit levels of the Dual Choice PPO plan are underwritten by Kaiser Permanente Insurance Company (KPIC).

Consumer Choice Option (CCO) Enrollment

Have any of your employees opted for the CCO option? ☐ Yes ☐ No

If yes, additional premium collected by: ☐ Employer deduction from employee paycheck ☐ Kaiser Permanente bills the employee

4 ADMINISTRATIVE

Annual Enrollment Period From To	Positive Enrollment ☐ Yes ☐ No (election required)	Ongoing Enrollment Method ☐ Paper Application ☐ Electronic Files ☐ Account kp.org (Registration application required)
Account Structure We can set up separate bill groups when you require premium to be allocated and reconciled by division or department. Do you require separate bill groups? ☐ Yes ☐ No		

Bill Group Name

Bill Group Name

Bill Group Name

5 DEDUCTIBLE AND OUT OF POCKET MAXIMUM ACCUMULATIONS

Choose Your Accumulation type: ☐ Calendar Year (Customary; January 1 -December 1) ☐ Plan Year

If Plan Year, select the start month of accumulation:	☐ FEB	☐ MAR	☐ APR	☐ MAY	☐ JUN	☐ JUL	☐ AUG	☐ SEP	☐ OCT	☐ NOV	☐ DEC

6 GROUP HEALTH STATUS

To the best of your knowledge, have any employees or dependents of employees been diagnosed or treated during the past 24 months for a serious health problem such as Acquired Immunodeficiency Syndrome (AIDS); Human Immunodeficiency Virus (HIV) Positive Status; Alzheimer's Disease; Cancer; Diabetes; Heart Disease; Hemophilia; Liver Disease; Kidney Disease; Mental Illness; or Substance Abuse?

☐ Yes ☐ No If yes, provide details below.

Patient Age	Sex	Relationship to Employee	Claim Amount	MM/YY of Treatment	Condition	Degree of Recovery
1.						
2.						
3.						
4.						

Has anyone within the past 12 months been hospitalized, institutionalized, or missed work due to disability or injury?

☐ Yes ☐ No If yes, provide details below.

Patient Age	Sex	Relationship to Employee	Claim Amount	MM/YY of Treatment	Condition	Degree of Recovery
1.						
2.						
3.						
4.						

7 MONTHLY PREMIUM CONTRIBUTIONS

Write the Kaiser Permanente plan type (i.e., HMO, PPO, POS, etc.) in the top row, and the employee cost per month for that plan type in the rows below it.

Plan Type:						
	Employee Cost/ Month ($)	Employee Cost/ Month ($)	Employee Cost/ Month ($)	Employee Cost/ Month ($)	Employee Cost/ Month ($)	Employee Cost/ Month ($)
Employee Only						
Employee + Child						
Employee + Spouse						
Employee + One						
Employee + Children						
Family						

Continued

7 MONTHLY PREMIUM CONTRIBUTIONS CONTINUED

Additional Carrier

If another carrier is offered along with Kaiser Permanente, please complete the following. (If more than one additional carrier, attach another sheet.)

Carrier Name

Plan(s) Offered:
☐HMO ☐PPO ☐POS ☐HSA

Funding Arrangement:
☐Fully Insured ☐Self-Funded

Write the plan type (i.e., HMO, PPO, POS, etc.) in the top row, and the rates and the employee cost per month for that plan type in the rows below it.

Plan Type:						
	Rate	Employee Cost/ Month ($)	Rate	Employee Cost/ Month ($)	Rate	Employee Cost/ Month ($)
Employee Only						
Employee + Child						
Employee + Spouse						
Employee + One						
Employee + Children						
Family						

8 EMPLOYER INFORMATION

Employer acknowledges that this plan constitutes an employee welfare benefit plan and agrees, as "sponsor", to fully comply with the applicable provisions and requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Employer designates Health Plan and/or KPIC, as applicable, as the named fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the administrator of employer's employee benefit plan as that term is defined under ERISA.

This provision only applies to an employer who sponsors an employee welfare benefit plan covered by ERISA, and where Health Plan's and/or KPIC's group health coverage is a component of that employee welfare benefit plan.

Group represents and warrants that Group complies with eligibility requirements, pursuant to applicable federal and state law, directly and indirectly related to the group health plan including but not limited to those pertaining to waiting periods and orientation periods.

In addition, Group agrees that enrollment data provided by the Group to Health Plan will include coverage effective dates for Group's employees and dependents in accordance with all group health plan eligibility requirements including but not limited to those associated with waiting periods and orientation periods.

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).

I understand and agree, on behalf of the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that this Application and my answers (a) will become part of any Group Agreement which may ultimately be issued by Health Plan; (b) will become part of any Group Policy which may ultimately be issued by KPIC; and (c) are made to induce Health Plan and/or KPIC, as applicable, to issue the group coverage(s) as applied for.

Any intentional material misstatement or omission of information made on this application will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information, without liability to Health Plan, KPIC, and The Southeast Permanente Medical Group, Inc.

Signed this _____ day of _____	City	State

By (Signature of Authorized Company Officer	Title
X	

Premium deposit collected:

$

Broker Designation:

I hereby designate (Broker name) as the broker of record.

Signature of Authorized Company Officer	Date
X	/ /

9 BROKER INFORMATION

☐ Please check box if this is to replace address currently on file.

Agent/Broker's Statement:
To the best of my knowledge and belief, employment, and other information supplied in the group enrollment application is true and complete. 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 have 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.

Agent/broker name		License number
Office phone	Fax	Cell phone
Email		
Firm name		EIN/TIN

Street address	City	State	ZIP

Agent/broker signature	KP Broker #	Date
X		/ /

General Agent Stamp

10 UNDERWRITING REQUIREMENTS AND ASSUMPTIONS

The proposed rates that accompany this document are not final until you sign your Group Agreement and/or Group Policy, as applicable verifying the terms of your agreement with us, including the conditions of offering and any changes for the contract year, or until you pay any portion of the Monthly Membership Charges for the contract year. These proposed rates are based on the terms and conditions listed below unless explicitly stated otherwise in the Rate Proposal. If you fail to meet any of the Underwriting Requirements and Assumptions at any time, we may withdraw our rate proposal, re-rate or terminate your Group Agreement and/or Group Policy.

The rates are valid for a 12-month period following the effective date unless explicitly stated otherwise or if either of the following events occur:

- A government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by net income) upon Health Plan, Medical Group or its physicians, or Kaiser Foundation Hospitals (or any of our activities).
- There is a cost associated in complying with newly enacted legislation. Then beginning on the effective date of that tax, charge, or legislation, we may calculate your rates to include your share of the new or increased tax or charge or cost of legislative compliance.

Minimum contribution, participation, and other group requirements:

- The greater of five or 5 percent of the active, eligible employee subscribers must be enrolled in our plan if we are offered alongside another carrier.
- At least 75 percent of all eligible employees must enroll in the group health plans offered by the employer.
- All eligible employees must work at least 20 hours per week.
- Contributions must be at least 50 percent of the employee-only rate.

Continued

10 UNDERWRITING REQUIREMENTS AND ASSUMPTIONS CONTINUED

- There must be a bona fide employer/employee relationship between the employee and all eligible employees offered our plan with the exception of eligible Taft-Hartley trusts and partnerships.
- 100 percent of your eligible employees must be covered by Worker's Compensation, unless not required by law to be covered.

The contracting employer must offer enrollment in this plan to employees on conditions that are no less favorable than those for any other plan that the employer makes available. A few examples include, but are not limited to the following:

- Employer must offer our plan to all eligible employees.
- We must have equal access to you and your employees as all other plans offered.
- The employer must not have a discriminatory contribution arrangement that is unfair to us. For example, an acceptable formula includes one in which you apply a uniform equal dollar employer contribution, or an equal percentage contribution.
- Basic and optional benefits, such as prescription drugs and infertility, must be comparable among all plans offered.
- When domestic partner coverage is provided, it must be provided on the same basis for all plans.
- The rate ratios of the plans offered must be aligned. The rate steps (and their definitions) of the plans offered must be uniform.
- If early retirees are covered, the employer must offer all plans to early retirees on the same basis.
- The eligibility rules (e.g., dependent age limits and waiting periods for new hires) must be consistent across all plans.
- The employer will not allow any preferential treatment to be given to another plan offered.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement, Group Policy, Evidence of Coverage, and/or Certificate of Insurance, as applicable.

Employer By:	Title	Date / /

Nine Piedmont Center • 3495 Piedmont Road, NE
Atlanta, GA 30305 • 404-364-7000
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