KAISER PERMANENTE®

2023 Georgia Small Group
EMPLOYER APPLICATION

Email application to your Kaiser Permanente representative or your broker.

Requested effective date ____/____/____

1 ABOUT YOUR 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	Fax
( ) –	( ) –

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)	Website
/ /				

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 date: / /

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 1 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 ( ) –		

Business name (please print):_____

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 50 or fewer, skip the following and go to section 3C.

If your total number of employees noted above is more than 50, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to **healthcare.gov** or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 50 full-time and full-time-equivalent employees on average of the previous calendar year.

Total _____

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: _____

Employee only coverage:[1] ☐ 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

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?[2] ☐ Yes ☐ No If you don't select an answer, we'll record your status as Yes.

[2] 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 aren't. 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?[3] ☐ Yes ☐ No

[3] 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. **Your minimum contribution must be at least 50% of the "employee only" monthly premium for the lowest-priced Kaiser Permanente medical plan offered by you, the employer.**

Percentage of the premium is based on the following **(select 1 only)**:
☐ Lowest plan offered ☐ All plans offered ☐ Specific plan offered: _____

Employer contribution (50%–100%): _____ % per employee _____ % per dependent **(optional)**

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

Business name (please print): _____

7 RENEWAL DELIVERY

Your annual renewal notification and packet will be sent to you by USPS mail, prior to your health coverage anniversary date. Delivery will be to the business' physical street address on this application.

8 CONTRACT SIGNER INFORMATION

There's only 1 contract signer. This principal person is responsible for signing this application, providing renewal information, and 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.	Fax ( ) –	Cellphone ( ) –	
Email		How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail		

9 BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information. Only 1 billing contact is allowed.

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

First name	MI	Last name		
Mailing address		City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cellphone ( ) –	
Email		How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail		

10 MEDICAL PLANS

Please select the plan(s) you would like to offer. For more information on the plans listed below, contact your sales representative or agent/broker. You're eligible to offer a choice of plans to your employees.

Platinum	☐ Platinum KP 0/0/20/S10	☐ Platinum KP 500/20/20/S10	☐ Platinum KP Plus 0/0/20/S10	☐ Platinum PPO 0/0/20/S10
Gold	☐ Gold KP 0/0/30/S10 ☐ Gold KP 0/0/40/S10 ☐ Gold KP 1000/20/30/S10	☐ Gold KP 2250/20/30/S10 ☐ Gold KP 2500/0/30/S10 ☐ Gold KP 3500/0/30/S10	☐ Gold KP 3750/20/30/S10 ☐ Gold KP 4500/0/30/S10 ☐ Gold KP Plus 0/0/30/S10 ☐ Gold KP Plus 1000/20/30/S10 ☐ Gold KP Plus 2500/0/30/S10	☐ Gold PPO 1000/20/30/S10 ☐ Gold PPO 2500/10/30/S10 ☐ Gold KP Virtual Complete 3000/20/40/S10
Silver	☐ Silver KP 2700/35/50/S10 ☐ Silver KP 3700/35/50/S10 ☐ Silver KP 4700/35/50/S10 ☐ Silver KP 5500/0/50/S10 ☐ Silver KP 6000/30/50/S10	☐ Silver KP Plus 2700/35/50/S10 ☐ Silver KP Plus 3700/35/50/S10 ☐ Silver HDHP/3200/20/S10 ☐ Silver HDHP/5000/20/S10	☐ Silver PPO 3850/30/50/S10 ☐ Silver PPO 4850/30/50/S10	☐ Silver PPO/HDHP 3500/20/S10 ☐ Silver PPO/HDHP 5000/20/S10 ☐ Silver KP Virtual Complete 5000/30/40/S10
Bronze	☐ Bronze HDHP/6850/0/S10	☐ Bronze PPO 6500/20/60/S10	☐ Bronze PPO/HDHP 6850/10/S10	☐ Bronze KP Virtual Complete 6300/20/60/S10

The Dual Choice PPO plans are fully underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan (KFHP), Inc.

Business name (please print):_____

11 IMPORTANT INFORMATION - PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), 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.

12 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by broker. To the best of my knowledge and belief, the 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 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.

Primary (authorized agent/broker)

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

Secondary (Only if adding another firm; doesn't apply to a second agent/broker at the same firm)

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

Business name (please print):_____

13 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP 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 KFHP and KPIC for new employees.
- Employees must be full-time, working 30 or more hours per week, and earning compensation equal to a minimum of the federal minimum wage. 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 will abide by the contract provisions.

Domestic Partner Coverage
Coverage for state-registered (civil union) domestic partner coverage is included in all small group plans. You may also offer coverage to those who are not registered with this state. Kaiser Permanente is not advising on whether or not the law requires coverage of these individuals. Please seek guidance from your counsel on dependent coverage obligations.

Approval may be withheld for any reason permitted under applicable state and/or federal law. The employer understands the licensed broker, if any, who solicited this application was acting as an independent contractor and not as a broker of the Health Plan and/or KPIC, as applicable. Furthermore, the broker who solicited this agreement or upon whose explanation of coverage and benefits employer relied is in fact employer's broker for purposes of this agreement. It's understood that as an independent contractor and as employer's broker that person has no right to bind this coverage or to alter terms or conditions of any policies or any enrollment applications or to waive any requirements of Health Plan and/or KPIC, as applicable, or to adjust any claims for benefits under this insurance for which employer is applying.

The employer acknowledges and agrees that coverage under any policy will only be as and to the extent provided, and it's employer's duty and responsibility to explain this to each person for whom coverage is sought. Employer has reviewed the benefits and limitations of coverage in the benefits summary and has explained such benefits and limitations to each person for whom coverage is sought. It's also acknowledged and agreed that coverage will begin only: upon the effective date inserted by Health Plan and/or KPIC, as applicable in the written notice to employer. The absence of written approval won't imply approval. Approval may be withheld for any reason permitted under applicable state and/or federal law.

Employer may cancel this agreement at any time upon 30 days prior written notice to Health Plan and/or KPIC, as applicable. For the duration of coverage, employer agrees to pay premiums on a monthly basis or at such other frequency as agreed upon by Health Plan and/or KPIC, as applicable. If Health Plan and/or KPIC, as applicable doesn't receive payment in full within the time allowed, this will automatically constitute withdrawal and cancellation of all coverage. The effective date of coverage termination will be 12:01 a.m. of the first day of the billing period for which the premium wasn't paid when due if: (1) coverage is terminated because of nonpayment of premium in full; or (2) employer has given prior written notice of cancellation. Coverage for the participating employees and their dependents will be continuous unless (1) the employee terminates employment; (2) the employee or dependent ceases to be eligible; or (3) requirements of this agreement aren't maintained by the participating parties here-under, including employer and employees.

Pediatric dental is an Essential Health Benefit. When employees and their dependents enroll in the medical plan, members receive child dental benefits as part of their medical coverage and not as a separate plan. Child dental benefits apply to all members under 19 years of age. This is not applicable to SHOP Plans.

The employer is establishing this plan to provide medical and other benefits to its eligible employees and dependents. 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 fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the Plan 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.

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).

Business name (please print):_____

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I have a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that at least 50% of eligible employees are covered by group coverage. Failure to maintain the participation requirements may result in non renewal of contract.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ga**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

The annual renewal notification and packet will be sent by USPS mail, prior to the health coverage anniversary date. Delivery will be to the business' physical street address on this application.

The group agreement and interim communications will be delivered either by email or mail as designated by the Contract Signer.

Any employees who are covered for health care under CHAMPUS/CHAMPVA, Medicare, Individual, or their spouse's or parent's group coverage may waive health coverage. The participation calculation would apply to the remaining eligible employees. The employer will (1) maintain the records necessary to the administration of the agreement; (2) report additions, changes, terminations, and other information necessary to the administration of the agreement to Health Plan and/or KPIC, as applicable, within 30 days after the effective date of such additions, changes, and terminations; (3) agree that if employer doesn't notify Health Plan and/or KPIC, as applicable, of any insured ineligibility or termination within 30 days, shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax return, and personnel files and other documentation as determined by the Health Plan and/or KPIC, as applicable, available upon request to the Health Plan and/or KPIC, as applicable, or its authorized representative; (5) pay all premiums in accordance with the terms of this agreement; and (6) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate contributions made by the employee towards the premium.

All statements provided in this agreement are true, correct, complete, and within our personal knowledge. We understand and agree that this agreement will become binding between Health Plan and/or KPIC, as applicable, and us only upon acceptance by Health Plan and/or KPIC, as applicable. The absence of written approval won't imply approval. Any intentional material misstatement or incomplete statement of fact will be deemed a misrepresentation and may result in termination of all coverage with respect to us, our participating employees, and their dependents without liability to Health Plan and/or KPIC, as permitted by applicable law.

Authorized company signer (please print name)	Title (please print)
Signature of authorized company officer X	Date