KAISER PERMANENTE®

Employer Designation and Authorization Form
For Kaiser Permanente

Date:

To: Kaiser Foundation Health Plan, Inc.

Please recognize _____as our designated insurance broker/consultant for Kaiser Foundation Health Plans. This recognition also entitles them to receive all allowed commissions/fees and service allowances in conjunction with the placement, installation and/or servicing of our insurance contract/agreement.

This letter also constitutes your authority to furnish our designated broker/consultant with all the information that they may request as it pertains to our agreement, rates, benefits, and other data that they may wish to obtain.

We understand that our designated broker/consultant has no responsibility for any deficiencies in the insurance program to which this letter applies until they have had reasonable opportunity to review our policy.

This letter supersedes any agreements previously issued by our company to Kaiser Foundation Health Plan, Inc. This authorization shall remain in effect until such time as it is rescinded in writing.

Sincerely,

_____ _____

Signature of Decision Maker Date

_____

Print or Type Name of Decision Maker

_____

Name of Company

Kaiser Foundation Health Plan Group # ☐

Renewal Month ☐

KAISER PERMANENTE HAWAII REGION (KPHI)

BR Form #002