KAISER PERMANENTE®

Hawaii Region

CUSTOMER RATE REQUEST FORM

Clear Form | Print

***Required Fields** **For employer groups of 51 or more full-time employees ONLY**

SECTION A – EMPLOYER INFORMATION		
*Legal Business Name:		
*DBA:		
*DOL#:		
*Federal Tax ID#/EIN:	*Industry/SIC:	
*Primary Contact Name:	*Title:	
*E-mail:		
*Phone	Fax:	
Secondary Contact Name:	Title:	
E-mail:		
*Phone:	Fax:	
*Hawaii address:		
*City:	*State:	*ZIP Code:
*Billing address:		
*City:	*State:	*ZIP Code:
*What month does your current carrier contract renew?	*What month do you want coverage to begin with Kaiser?	
Do you plan to offer Kaiser alongside another carrier? ☐ Yes ☐ No If yes, which carrier:		
Are you affiliated with a PEO? ☐ Yes ☐ No If yes, which one:		
Have you offered Kaiser health insurance to your employees in the past? ☐ Yes ☐ No Reason for cancellation:		
Do you or your TPA handle COBRA billing and administration? ☐ Yes ☐ No If no, would you like Kaiser to bill your COBRA members directly? ☐ Yes ☐ No		
Do you recognize domestic partners as an eligible dependent? ☐ Yes ☐ No		

SECTION B – BROKER INFORMATION (IF APPLICABLE)		
*Broker's Firm:		
*Broker's Name:		
E-mail:		
*Phone	Fax	
Current address:		
City:	*State:	*ZIP Code:
*Hawaii Insurance Producer License:		*Expiration Date:
*Appointed by Kaiser? ☐ Yes ☐ No		
*Please mail my contract to: ☐ EMPLOYER ADDRESS ☐ BROKER ADDRESS		

SECTION C – CURRENT PLAN INFORMATION	
Current Carrier:	Plan(s) Name:
Employer contribution for employee? %	Employer contribution for dependent? %

Current Benefits – Check all that apply *In lieu of this section, you may submit a copy of your plan benefits.* ☐ None. Please explain:_____ ☐ Medical Only ☐ Medical & Drug ☐ Medical, Drug & Vision ☐ Medical, Drug, Vision & Dental ☐ Chiropractic ☐ Other:_____	Current and Renewal Rates *In lieu of this section, you may submit a copy of a recent bill.* Current Rates: Renewal Rates: If possible, please provide rate history for the past 3 years:

SECTION D – EMPLOYEE CENSUS

***Please complete attached 51+ Excel Census file and submit along with this Customer Rate Request Form.**

A. Total # of Full-Time Employees	
B. Total # of Part-Time Employees	
C. TOTAL # OF FULL-TIME EMPLOYEES ELIGIBLE FOR COVERAGE WITHIN HAWAII *Active employees who work 20+ hours*	
D. TOTAL # OF ELIGIBLE EMPLOYEES WAIVING COVERAGE WITHIN HAWAII *Waivers are defined as employees who are eligible for coverage under their employer's plan but voluntarily decline because they are covered elsewhere. Examples of other coverage include: spousal plan coverage, veteran coverage, or Medicare coverage.*	
E. TOTAL # OF EMPLOYEES YOU WILL BE PROVIDING COVERAGE FOR (# PARTICIPATING) WITHIN HAWAII *Total Participating = Total Eligible Employees - Total Waiving* *List these employees in the census grid.*	

SECTION E – EMPLOYER MEDICAL QUESTIONNAIRE

Please complete to the best of your knowledge, all three sections below. This questionnaire applies to all your employees and their dependents. Please note that Kaiser Permanente relies on information provided in the Employer Medical Questionnaire and information from our medical records system for those individuals with prior Kaiser Permanente membership to establish rates.

SECTION 1: EMPLOYER MEDICAL PROFILE CASES- List the number of cases that have occurred in the past 24 months

Medical Condition	# of Cases	Medical Condition	# of Cases
• Acquired Immune Deficiency Syndrome (AIDS)		• Kidney Disorder / Disease	
• Allergy / Asthma		• Liver Disorder / Disease	
• Blood Disorder – Leukemia		• Lupus	
• Birth Abnormalities / Injuries		• Mental / Nervous Disorders	
• Cancer		• Multiple Sclerosis / Muscular Dystrophy	
• Chest Pain / Coronary Disease		• Paralysis	
• Lung / Pulmonary Disease		• Pregnancy (In Section 3, List estimated date of delivery)	
• Diabetes		• Stomach / Intestinal Disorder	
• Epilepsy		• Stroke	
• Hypertension		• Transplant	
• High Cholesterol		• Tumor / Cysts	
• Implants / Prosthesis		• Urinary Tract Disorder	

SECTION 2: EMPLOYER MEDICAL PROFILE QUESTIONS- Check either Yes or No to questions that apply in the past 24 months		
Has any employees or dependents incurred medical claims in excess of $5,000?	☐ NO	☐ YES
Are there any employees currently not performing their assigned work responsibilities because of a disabling injury or illness?	☐ NO	☐ YES
Are there any employees or their dependents who have been diagnosed or treated for a serious medical condition not listed above, including those not enrolling for coverage?	☐ NO	☐ YES
Has any employee or dependent been hospitalized, institutionalized, or missed work or school for more than seven consecutive days due to any disability, health condition, or work-related injury?	☐ NO	☐ YES

SECTION 3: EMPLOYER MEDICAL PROFILE DETAIL DESCIRPTION- Provide detailed explanations to any cases listed in Section 1 or any questions answered Yes in Section 2. Attach a separate sheet if needed.

Medical Condition	Diagnosis	Treatment (Type and dates of treatment)	Prognosis (outcome)

SECTION F – ELIGIBILITY REQUIREMENTS/ATTESTATION

Documentation Requirements

To obtain a rate proposal from Kaiser Permanente, please submit:

- Completed Customer Rate Request, including signature
- Employee Census

Eligibility requirements for Employer-sponsored group health plans

1. The identified employer certifies that they are a legitimated business operation that must provide medical coverage to their employees on payroll based on the Hawaii Prepaid Health Care Act (HPHCA). For information on the HPHCA and other employers' requirements, including workers' compensation (WC) and temporary disability insurance (TDI), please contact the State of Hawaii Department of Labor and Industrial Relations, Disability Compensation Division at 808-586-9161.
2. The identified employer certifies that their company is a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage. The identified employer agrees that a bona fide employer/employee relationship exists with respect to each subscriber to be enrolled. This requirement does not apply to eligible Taft-Hartley trusts and partnerships.
3. The identified employer agrees that all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are "Eligible Employees" of the employer, or a subsidiary or affiliate listed within this request. "Eligible Employee" means an employee who works for a Group employer on a full-time basis, works 20 or more hours per week for four consecutive weeks, earns a monthly wage of 86.67 times the Hawaii minimum hourly wage, has satisfied applicable waiting period requirements, and is not a part-time, temporary, seasonal or substitute employee or independent contractor who receives a 1099 statement.
4. The identified employer agrees that it assumes responsibility for, and all liability related to, its determinations regarding the eligibility status of each Eligible Employee and his/her Dependents. The identified employer agrees it will be financially liable to Kaiser Permanente for any errors and/or omissions.
5. The identified employer agrees that the Group medical coverage applied for in this request will not become effective until:

    a. This request is approved by Kaiser Permanente; and
    b. An advance payment equal to an estimated one month premium is received by Kaiser Permanente.

Please do not cancel any existing coverage until you have accepted final rates and all required documents have been approved and accepted by Kaiser Permanente.

By continuing to pay Group premium on this renewing plan, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Eligibility requirements as defined in the Prepaid Health Care Act continue to apply for employees eligible for coverage under the Prepaid Health Care Act.

I, the undersigned, hereby represent and warrant that the information provided on this Customer Rate Request, Employee Census and Employer Group Questionnaire is true and accurate for the identified employer. I understand that Kaiser Foundation Health Plan, Inc. will rely on this information to establish health care coverage for the identified subscribers if the Health Plan decides to enroll the customer. If any of this information is untrue or inaccurate, Kaiser Foundation Health Plan, Inc. will be able to terminate the identified customer or take other appropriate actions that will directly impact the employer, its members, and the prices of any coverage that may be provided.

If applicable, I, the undersigned, hereby authorize the below broker to request all information as it pertains to our agreement, rates, benefits, and other data he/she may wish to obtain.

*Name:	*Title:
*Signature:	*Date:
*Broker Name:	*Broker Firm:
*Signature:	*Date: