KAISER PERMANENTE®

Small Business
NEW GROUP APPLICATION

Email application to your Kaiser Permanente representative or your broker.

Effective date _____

1 COMPANY INFORMATION

Company name

Doing business as (DBA) | Website

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

DOL (Department of Labor) Number | Federal tax ID (EIN) number | NAICS code (6 digits - visit naics.com/search)

Hawaii Address | City | State | ZIP

Billing Address (if different from above) | City | State | ZIP

Primary Contact Name | Title | Email

Phone | Fax

Secondary Contact Name | Title | Email

Phone | Fax

☐ By checking this box, I acknowledge that our group will be automatically enrolled in paperless billing unless otherwise stated.

2A 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 and must apply as 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

2B EMPLOYEE COUNT

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

Full-time Total _____ Part-time Total _____

Please provide the total number of employees in Hawaii.

Full-time Total _____ Part-time Total _____

2C ELIGIBLE EMPLOYEES

Please provide the total number of employees eligible for healthcare in Hawaii (See Section 7 - #3). Total _____

Total number of eligible employees waiving coverage within Hawaii. Total _____

Waivers are defined as employees who are eligiblefor coverage under their employer's plan but voluntarilydecline because they are covered elsewhere.

Examples of other coverage include: spousal plan coverage, veteran coverage, or Medicare coverage.

If you have 20+ total employees, a COBRA subgroup will be set up for group administration only.

Company name (please print): _____

3 COMPANY PREMIUM CONTRIBUTION

Current Carrier	Plan(s) Name
Employer Contribution for employee by percentage	Employer Contribution for dependent by percentage
Current Rates:	Renewal Rates

4 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 ID and company name.

☐ Yes ☐ No Group ID Company Name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal date:

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: Number of employees enrolled:

5 CONTRACT DELIVERY PREFERENCE

We'll deliver your Kaiser Foundation Health Plan, Inc. (KFHP)/Kaiser Permanente Insurance Company (KPIC) contracts online in a PDF file at **account.kp.org** unless you indicate below that you'd like your contract(s) mailed to you.

☐ I want to receive my contract(s) by mail. Please mail to:

☐ Employer Address

☐ Broker Address

6 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

Please recognize the below 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.

☐ Yes ☐ No

Agent name		License number	
Phone	Fax	Cell phone	
Email			
Firm name		Kaiser Permanente broker firm ID	
Street address	City	State	ZIP
Agent/broker signature X		Date	

Company name (please print): _____

7 ELIGIBILITY REQUIREMENTS/ATTESTATION

Rate quote proposals are processed and returned within five (5) working days of receipt of the completed and acceptable new group application.

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 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.

Company name (please print): _____

I, the undersigned, hereby represent and warrant that the information provided on this New Group Application 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.

The undersigned attests that they have purchased or will purchase an Exchange-certified stand-alone pediatric dental coverage plan from any insurer whether purchased "on" or "off" the Exchange, in order to be eligible to purchase a medical plan that excludes pediatric dental coverage, unless they enroll in an adult dental plan through Kaiser Permanente that has pediatric dental benefits embedded. The undersigned acknowledges that the Patient Protection and Affordable Care Act requires that pediatric dental be included as an essential health benefit for customers of small group and individual health insurance policies.

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.

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

Broker Name	Broker Firm
Signature X	Date

Reset Print