KAISER PERMANENTE®

Maryland Small Group

# BROKER OF RECORD AUTHORIZATION
(New Group)

## 1 COMPANY INFORMATION

| Company name | Federal tax ID (EIN) number |
|---|---|
| | |

## 2 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

**To be completed by your Kaiser Permanente-appointed agent/broker after completion of this form.** If you are a broker who is not licensed and appointed to sell Kaiser Permanente, or your information has changed, please contact Broker Support at **844-268-2943** or via email at **brokersupport-mas@kp.org**.

| Agent name | License number |
|---|---|
| | |
| Contact email | Contact phone |
| | |
| Firm name | Kaiser Permanente broker firm ID |
| | |

## 3 AGENT/BROKER AUTHORIZATION

By submitting and signing this request:

- I, for the undersigned group, hereby request to designate the agent/broker named above as our authorized agent/broker for Kaiser Foundation Health Plans.
- I authorize our designated agent/broker to complete, sign and submit forms on behalf of the group without the need for a signature from the group. I agree to be bound by transactions performed by the agent/broker on our behalf. This includes our agent/broker submitting an *Employer Application* form to contract with Kaiser Permanente for Small Group health care coverage.
- I authorize you to discuss and provide group-specific information to our designated agent/broker. This information includes, but is not limited to, our group plan agreement, rates, benefit, payment information and, to the extent permitted by applicable law, protected health information (PHI).

## 4 GENERAL AGENT ACCESS

Your agent/broker may work with a General Agent (GA) to service your organization, which is a different firm from your agent/broker. The same agent/broker access to your group-specific information and change permission will be granted to a designated GA unless you choose not to authorize access.

**Do not check the box below if you consent.**

☑ Check this box **ONLY** if you **DO NOT** authorize a GA to access your group-specific information, service your organization, change group information, or act on your behalf.

## 5 CONTRACTING AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP-MAS and KPIC, I agree that:

- The effective date will be determined by KFHP-MAS/KPIC and will be the latest of:
  a. the date this application is given written approval by KFHP-MAS/KPIC; or
  b. any requested effective date not prior to the date the applicant signs this agreement and KFHP-MAS/KPIC approves the application; or
  c. the date KFHP-MAS/KPIC establishes for coverage to begin, in the event that this application is not accompanied by all information needed by KFHP-MAS/KPIC.
- Full first month's payment must be received and KFHP-MAS/KPIC must approve the application in writing for the plan to become effective.
- 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 forms provided or approved by KFHP-MAS and KPIC for new employees.
- In submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The applicant is not the agent or representative of KFHP-MAS/KPIC for any purpose of this application or any group agreement issued pursuant to this application.
- The eligibility data provided by my company to KFHP-MAS/KPIC 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 acknowledges that the effective date of coverage for new employees and their eligible family dependents will not exceed the waiting period established by my company. All full-time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date of KFHP-MAS's *Group Agreement* or KPIC's *Group Policy*.
- My company will abide by the contract provisions. I agree to provide KFHP-MAS/KPIC, in writing, proof of group and employee eligibility. KFHP-MAS/KPIC reserves the right to inspect the records of the group in order to verify the eligibility of employees and their dependents. Copies of the quarterly employee wage report and appropriate employer tax documentation may be required for any group at the discretion of KFHP-MAS/KPIC.

**Domestic Partner Coverage**

- Coverage for state-registered (civil union) domestic partners is included in all small group plans. If children of the insured employee are covered, children of state-registered domestic partners are covered on the same basis.
- Employers may choose to provide coverage to domestic partners who are not registered with the state. Please refer to the Employer Application you submitted: If "Yes" is selected in Section 3D, and children of the insured employee are covered, children of non-state-registered domestic partners are covered on the same basis.

Kaiser Permanente is not advising on whether or not the law requires coverage for these individuals. Please seek guidance from your counsel on dependent coverage obligations.

- In addition, the group must annually complete and return, in advance of the contract anniversary date, any and all documents requested by KFHP-MAS/KPIC in order to certify the group as a small employer.

I certify that my company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage. I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I attest that the minimum participation requirement of eligible employees are covered by the group. In applying the minimum participation requirement to determine whether the [0-75%] of participation is met, KFHP-MAS/KPIC may not consider as eligible employees: those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Standard Plan; or employees who are under the age of 26 years who are covered under their parent's health benefit plan.

I understand that unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except dependents and those former members covered under a continuation of benefits, are "eligible employees" of the applicant, or of a subsidiary or affiliate listed within this application. "Eligible employee" means an employee who is offered coverage under a health benefit plan by a small employer."Eligible employee," at the option of the small employer, may include: (1) only full-time employees; or (2) full-time employees and part-time employees.

I agree to furnish KFHP-MAS/KPIC all data necessary for the efficient administration of the group coverage for the approved covered employees and dependents, if any.

## 5 CONTRACTING AGREEMENT AND SIGNATURE (CONTINUED)

It is understood and agreed that none of KFHP-MAS/KPIC's agents have the authority to:

- modify this application form;
- waive the answer to any question on this application form;
- bind KFHP-MAS/KPIC in any way by giving or receiving any data which is not written on this application form;
- alter or amend the Group plan or plans; or
- bind KFHP-MAS/KPIC by making any promise or representation not contained in this application form.

The employer agrees to the following:

- that this application is offered as an inducement for the group coverage applied for;
- that this application will form a part of any contract issued;
- that only the information in this application will bind KFHP-MAS/KPIC;
- that no waiver or charge will bind KFHP-MAS/KPIC unless signed by an executive officer of KFHP-MAS/KPIC;
- that group coverage will only be provided for persons eligible under the plans issued; and
- that employer must maintain enrollment/waiver records for the purpose of regulatory state audits.

I agree to abide by the Kaiser Permanente deductible funding policy, which does not permit directly funding or reimbursing employees for any deductibles, coinsurance, or copays, in accordance with the federal tax laws for HSA plans or PPO medical plans.

I attest that my company is not participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage.

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 that a *Summary of Benefits and Coverage (SBC)* for each of my medical plans is available at **account.kp.org**.

I agree to provide my eligible employees with *SBC*s for any plan(s) I have chosen or change to in the future.

The agent or the broker does not have the power on behalf of KFHP-MAS/KPIC to make or modify any application for coverage, to make any promise or representation, or to waive any of the companies' (KFHP-MAS/KPIC) rights or requirements.

☑ **We are applying for coverage during the period that begins on November 15 and extends through December 15, thus not subject to a minimum participation requirement.**

**I understand and agree, as 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 such statements and answers:**

- **will become part of any *Group Agreement* which may ultimately be issued by KFHP-MAS/ KPIC; and**
- **are made to induce KFHP-MAS/KPIC to issue the group coverage as applied for.**

**I have the authority to make the statements and representations contained in this application and to execute this application on behalf of the group. If you have any questions concerning the benefits and services that are to be provided by or excluded under the coverage that is the subject of this application, please contact a membership services representative before signing this application.**

**Maryland State warning:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

| Authorized company signer (full name in print) | Title (please print) |
|---|---|
| Signature | Date |



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2023SG1373 MAS September 2023