Group Number Assigned:_____

KAISER PERMANENTE®

☐ **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street
Rockville, MD 20852

☐ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

DC, MD, and VA MID/LARGE Group Employer Application

Application is hereby made for group health coverage based upon the following statements and representations:

DO NOT ALTER THIS DOCUMENT EXCEPT TO FILL IN THE BLANKS AND CHECK THE BOXES PROVIDED. Due to regulatory requirements, this Application will not be accepted if any other changes are made. Complete this Application in its entirety, in black ink, and sign and return it to your sales representative. **If you have any questions concerning the benefits and services that are provided by or excluded under the benefit plan selected, please contact your account manager or sales representative before signing this application.**

Product*	Plan Name / Number	Service Delivery Options**
☐ HMO		☐ Signature ☐ Select
☐ Deductible HMO (DHMO) ☐ Everyday Care Plans		☐ Signature ☐ Select
☐ HSA-Qualified Deductible HMO (HDHP)		☐ Signature ☐ Select
☐ Added Choice POS ☐ [Added Choice 2T POS (Only Available in MD)]		☐ Signature ☐ Select
☐ Flexible Choice ☐ Deductible Flexible Choice ☐ HSA-Qualified Flexible Choice		Signature only
☐ Kaiser Permanente Plus ☐ Deductible Kaiser Permanente Plus		Signature only
☐ Virtual Forward ☐ Right Care Plans ☐ Virtual Complete		Signature only
KPMP ☐ HMO ☐ DHMO ☐ HSA-Qualified Deductible HMO (HDHP)		Signature only
☐ Out-of-Area PPO		
CDHC Options ☐ KP Administered HSA (available with HDHP and HSA-Qualified Flexible Choice only) ☐ KP Administered HRA ☐ KP Administered FSA ☐ KP Administered HRA / FSA		

****Benefits underwritten by KFHP-MAS: HMO, DHMO, Everyday Care Plans, HDHP, Added Choice POS, Option 1 of Flexible Choice, [Option 1 of 2T Added Choice POS], Virtual Forward, Right Care Plans, Virtual Complete, KPMP (HMO, DHMO, HDHP), Kaiser Permanente Plus, Deductible Kaiser Permanente Plus, Option 1 of Deductible Flexible Choice, Option 1 of HSA-Qualified Flexible Choice***

Benefits underwritten by KPIC: [Option 2 (Out-of-Network) of Added Choice 2T POS], Option 2 (PPO) and Option 3 (Out-of-Network) of Flexible Choice, Option 2 (PPO) and Option 3 (Out-of-Network) of Deductible Flexible Choice, Option 2 (PPO) and Option 3 (Out-of-Network) of HSA-Qualified Flexible Choice, and Out-of-Area PPO

****The Service Delivery Options only apply to the benefits underwritten by KFHP-MAS. They do not apply to the products underwritten by KPIC.***

Group Number Assigned:_____

DENTAL RIDER PLANS *(optional)*

District of Columbia & Maryland	Virginia
☐ [KP Smile ML $30 Adult Preventive – Age 19 or older]	☐ [KP Smile ML $30 Adult Preventive – Age 19 or older]
☐ [KP Smile ML Adult Dental PPO – Age 19 or older]	☐ [KP Smile ML Adult Dental C-POS– Age 19 or older]
☐ [KP Smile ML Dental Copay Basic]	☐ [KP Smile ML Dental Copay Basic]
☐ [KP Smile ML Dental Copay Low]	☐ [KP Smile ML Dental Copay Low]
☐ [KP Smile ML Dental POS Basic]	☐ [KP Smile ML Dental POS Basic]
☐ [KP Smile ML Dental POS Low]	☐ [KP Smile ML Dental POS Low]
☐ [KP Smile ML Dental POS Standard]	☐ [KP Smile ML Dental POS Standard]
☐ [KP Smile ML Dental EPO Low]	☐ [KP Smile ML Dental Network Only Low]
☐ [KP Smile ML Dental PPO Basic]	☐ [KP Smile ML Dental C-POS Basic]
☐ [KP Smile ML Dental PPO High]	☐ [KP Smile ML Dental C-POS High]
☐ [KP Smile ML Dental PPO Low]	☐ [KP Smile ML Dental C-POS Low]
☐ [KP Smile ML Dental PPO Premium]	☐ [KP Smile ML Dental C-POS Premium]
☐ [KP Smile ML Dental PPO Select]	☐ [KP Smile ML Dental C-POS Select]
☐ [KP Smile ML Dental PPO Standard]	☐ [KP Smile ML Dental C-POS Standard]
☐ [KP Smile Kids ML Dental Copay EPO]	☐ [KP Smile Kids ML Dental Copay]
☐ [KP Smile Kids ML Dental EPO]	☐ [KP Smile Kids ML Dental Network Only]
☐ [KP Smile Kids ML Dental PPO Basic]	☐ [KP Smile Kids ML Dental C-POS Basic]
☐ [KP Smile Kids ML Dental PPO]	☐ [KP Smile Kids ML Dental C-POS]
Cosmetic Orthodontic Rider	
☐ [OrthoPlus Family Rider]	☐ [OrthoPlus Adult Only Rider]
☐ [OrthoPlus Child Only Rider]	

Please provide the total number of Enrolling Employees participating in Dental Option:_____

Dental benefits are underwritten by KFHP-MAS and administered by Liberty Dental Plan. Groups may select 1 adult/family cosmetic orthodontic and/or 1 child cosmetic orthodontic plan.

Group Number Assigned:_____

SECTION 1 – Applicant's Information

Group's Legal Business Name (the Employer):				Group/Policy ID Number:
Doing Business As (DBA) (if applicable):	Group Organization: ☐ Corporation ☐ Partnership			
Corporate/Headquarters Address:	City, State ZIP Code:			
Executive Contact Person:	Title:	Phone:	Email:	Fax:

Primary Group Administrator:
The Primary Group Administrator is responsible for making membership administration actions like enrolling and terminating membership, updating demographic information, and ordering ID cards on behalf of the group via account.kp.org portal.

Full Name:	Title:	Phone:	Email:	Fax:

Federal Tax ID Number:	Primary NAICS Code:	Requested Effective Date:

Are there any affiliates or subsidiaries to be covered? ☐ Yes ☐ No If yes, please provide details below.

Company Name:	☐ Affiliate ☐ Subsidiary	Company Name:	☐ Affiliate ☐ Subsidiary
Address:		Address:	
City, State ZIP Code:		City, State ZIP Code:	

SECTION 2 – Employee Eligibility

	Live or Work Within the KFHP-MAS Service Area	Live and Work Outside the KFHP-MAS Service Area	Total
A. Total # of Full-Time Employees Working _____ Hours or More Per Week			
B. Total # of Permanent Part-Time Employees			
C. Total # of Employees Requesting Group Health Coverage			
D. Total # of Employees of All Affiliates, Subsidiaries and Offices			

SECTION 3 – Rates

	Employer Contribution %		HMO Rate	POS Rate	Out-of-Area PPO Rate
	HMO	POS			
Employee Only					
Employee + Adult					
Employee + Child(ren)					
Family					
Medicare					

SECTION 4 – Other Health Care Coverage Information

Have you ever had prior coverage with KFHP-MAS and/or KPIC? ☐ Yes ☐ No If yes, under what name?

If yes and coverage was provided, what was the Group/Policy ID number?

Are you applying for this insurance to replace current or prior coverage provided by another group health carrier? ☐ Yes ☐ No If yes, please provide the following:

Carrier's Name:	Group/Policy Number:	Effective Date:	Termination Date:

SECTION 4 – Other Health Care Coverage Information *(continued)*

Has an insurance carrier terminated your coverage in the past five years? ☐ Yes ☐ No If yes, please provide the following:

Carrier's Name:	Reason for Termination:
How many group insurance carriers provided coverage to you within the past 3 years?	Is your company exempt from COBRA or any state continuation plan? ☐ Yes ☐ No If yes, please explain._____

SECTION 5A – Broker Information

To be completed for broker sales only.

Broker Name:		Broker Firm Name:	
Street Address:		City, State ZIP Code:	
Agency Number:	Phone:	Email:	
National Producer Number (NPN):	Federal Tax ID Number:	General Agent Name:	Third Party Administrator (TPA):

By signing this Application, Applicant authorizes the individual named above to act as a broker of record for health plan coverage, through KFHP-MAS, and/or KPIC.

Effective _____ **Signed at** _____
Month Day Year City State

on _____ **Signature** _____
Month Day Year

Your broker is/may be paid commissions and other financial incentives by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and/or Kaiser Permanente Insurance Company.

SECTION 5B – 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.

SECTION 6 – Enrollment Information

Annual open enrollment period - Enroll during month of: _____ **for coverage effective** _____ **1st,** _____
Month Year

New employees coverage becomes effective: _____ ☐ months ☐ days of employment following Date of Hire (please select one).
Note: Maximum waiting period is 90 days from the date of hire.

Dependent Coverage – Limiting Age for Dependent Children:____
Such age may not be less than age 26.

☐ Coverage will not be provided to Domestic/Civil Union Partners++
☐ Coverage will be provided to Domestic/Civil Union Partners++

++Civil Union Partner - DC Only

SECTION 7 – Billing Information

Billing Address (Please list TPA address if using a TPA):	City, State ZIP:			
Contact for Billing:	Title:	Phone:	Email:	Fax:

Proration/Eff Status:	☐ **Full Month Proration:** Group is charged the full month's premium. Members are enrolled on the 1st of the month and terminated at the end of the month.	☐ **Half Month Proration:** Group is charged the full month's premium for enrollment between the 1st and 15th; no charge for enrollment between the 16th and 31st. Group is not charged the full month premium for terminations between the 1st and the 15th; Group is charged the full month for terminations between the 16th and end of the month.	☐ **Daily Proration:** Group is charged for the number of days in the month in which the subscriber is active based on a daily prorated premium.	☐ **Second Proration:** Group is charged the full month's premium. Members are enrolled on the 2nd of the month and terminated at the end of the month.

Jurisdiction:

SECTION 8 – Point-of-Service Options and Disclosure Statements

For District of Columbia only:
The following provisions that are noted below apply only if KFHP-MAS HMO is the sole offering for health care services: Under the District of Columbia law, your employees may purchase a point-of-service option as an additional benefit. A point-of-service option allows your employees to obtain covered health care services from physicians and other providers outside of the KFHP-MAS HMO network. You have the choice to pay the entire cost of the point-of-service options, pay a percentage of the cost of these options or require your employees to pay the entire cost of these options. The cost of the point-of-service options is identified in your proposal.
The applicant certifies that it has read and understands this disclosure statement and has provided notice of availability of these additional benefits to its eligible employees.

Point-of-Service Option Selection (please select one):

☐ The applicant declines the mandatory point-of-service offering.

☐ The applicant accepts the mandatory point-of-service offering. When the applicant accepts mandatory point-of-service offering, please indicate in Section 11 the employees who have chosen the point-of-service option (use a separate piece of paper if necessary).

For Virginia only:
Under the law of the Commonwealth of Virginia, your employees may purchase a point-of-service option as an additional benefit. A point-of-service option allows your employees to obtain covered health care services from physicians and other providers outside of the KFHP-MAS HMO network. KFHP-MAS offers a POS plan (Added Choice®) and, in conjunction with KPIC, Kaiser Permanente Flexible Choice to meet this statutory requirement. You have the choice to pay the entire cost of the point-of-service options, pay a percentage of the cost of these options or require your employees to pay the entire cost of these options. The cost of the point-of-service options is identified in your proposal.
Each eligible employee must indicate his/her selection of the mandatory point-of-service option. Failure to do so will result in HMO coverage only. Applicant must provide KFHP-MAS with a list of those eligible employees who have chosen the point-of-service option.
By signing this application, applicant certifies that it has read and understands this disclosure statement. Applicant further certifies that it has provided notice of availability of these additional benefits to its eligible employees.

For Maryland only:
The following provisions apply only if KFHP-MAS is the sole carrier offering health care or dental services. Under Maryland law, if you choose a point-of-service option, a dental point-of service option, or both for your employees, your employees may select the point-of-service option, the dental point-of-service option or both as an additional benefit. A point-of-service option allows your employees to obtain covered health services from physicians and other providers outside the HMO network. A dental point-of-service option allows your employees to obtain covered dental care services from dentists and other providers outside the dental provider panel. You have the choice to either pay for these point-of-service options, pay a percentage of the cost of these options, or require your employees to pay for the entire cost of these options. The cost of each point-of-service option is identified in your proposal. Please note, if the employer chooses a point-of-service option, it is the employer's responsibility to provide notice of the available option to its employees.

I have read and understand the disclosure statement and, if I have chosen the point-of-service option, I will provide notice of availability of this additional benefit to my eligible employees.

Point-of-Service Option Selection (please select one):

☐ Applicant DECLINES mandatory POS offering. **By declining, applicant understands that employees shall not be entitled to the mandatory POS as an additional benefit.**

☐ Applicant ACCEPTS mandatory POS offering.

Dental Point-of-Service Option Selection (please select one):

☐ Applicant DECLINES mandatory dental POS offering. **By declining, applicant understands that employees shall not be entitled to the mandatory dental POS as an additional benefit.**

☐ Applicant ACCEPTS mandatory dental POS offering.

SECTION 9 – Employer Agreement

The employer agrees to the following:

1) To offer enrollment in the KFHP-MAS/KPIC products to all individuals entitled to coverage on conditions no less favorable than those for any other health care plan available through the Group.
2) A bona fide employer/employee relationship exists with respect to each subscriber to be enrolled in the KFHP-MAS/KPIC products. This requirement does not apply to eligible Taft-Hartley trusts and partnerships.
3) As required by state law, Applicant has a workers' compensation coverage for its employees.
   ☐ **Group carries workers' compensation insurance.**
   ☐ **Group does not carry workers' compensation insurance.**
   If your company does not carry workers' compensation coverage, **please explain:**_____
4) To hold an open enrollment period at least once a year, during which all individuals entitled to coverage are offered a choice of enrollment in the KFHP-MAS/KPIC products and any other health care plan available through the group.
5) That the Group coverage applied for in this application will not become effective until:
   a) This application is approved by KFHP-MAS and/or KPIC; and
   b) On a date no later than the first day the coverage period begins, the premium is received by KFHP-MAS and/or KPIC.
6) That the agent or the broker does have the power on behalf of KFHP-MAS and/or 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.
7) That if it elects to be responsible for monitoring any or all aspects of enrollment eligibility, the employer will be financially liable to KFHP-MAS and/or KPIC for any errors and/or omissions.
8) We certify that our company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage. In addition, we certify that our company has been actively engaged in our business for at least three months prior to the date of this Application.
9) It has read and understands the POS options disclosure statement in Section 8 above, and if it has chosen a POS option and/or dental POS option, it will provide notice of the availability of these additional benefits to its eligible employees.

Group Number Assigned:_____

SECTION 10 – Group Acknowledgement

I understand and agree, on behalf of the employer, that the statements in this application and the answers to the Group Risk Questionnaire, if attached, are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers: a) will become part of any Group Agreement which may ultimately be issued by KFHP-MAS; (b) will become part of any policy or policies which may ultimately be issued by KPIC; and c) are made to induce KPIC and/or KFHP-MAS 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.

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).

Enrollees from the following states are to refer to their specific state warning:
District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime may be subject to fines and confinement in prison.
Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____
City State Month Day Year

By (full name in print) _____

Signature _____ **Title** _____

SECTION 11 – Additional Notes

Group Number Assigned:_____

For KFHP-MAS Use Only

Group Number Assigned:	Delivery System:	OAD/OAS:	Average Age:	Initial Contract Period Begins:	Initial Contract Period Ends:
Jurisdiction:	Plan:		Riders:		
Sales Representative (Print Name):					

BENEFITS	HMO	POS	OOA
Step Type			
Plan Type			
Rx			
Adult Dental / Pediatric Dental (Up to age 19)			
Copayment			
Coinsurance			
Deductible			
Out-of-Pocket Maximum			
Carve Out			☐ Rx ☐ None ☐ Chiro ☐ Other_____

STEPS	EMPLOYER CONTRIBUTION %		HMO RATE	POS RATE	OUT-OF-AREA PPO RATE
	HMO	POS			
Employee					
Two-Party					
Employee + Adult					
Employee + Child					
Employee + Children					
Family					