KAISER PERMANENTE®

2024 New and Renewing Large Group Application

All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Company's legal name	DBA(s)
Group number	

State in which the contract is based (select one) ☐ Oregon ☐ Washington (Clark and Cowlitz counties)

Coverage requested

☐ New coverage _____ Submit this application, copy of selected proposal(s), and enrollment forms. For timely processing, please return this form by the first of the month prior to your effective date.

☐ Coverage renewal ____ Complete sections I, III, V, VI, and VII. If you are making benefit changes or changes affecting your rate, attach a copy of the selected proposal(s).

Term of contract _____ through _____
Date Date

Is your group new to Kaiser Foundation Health Plan of the Northwest (KFHPNW)?
So that your application can be processed quickly, please use this coverage checklist to make sure the application materials are complete.

☐ Completed and signed application (includes tax identification number and workers' compensation information).
☐ Completed and signed employee enrollment forms and waiver information.
☐ Check made out to KFHPNW for the first month's premium (no postdated checks).

Section I: Plan and optional rider selection

Plans and riders offered and underwritten by **KFHPNW**

MEDICAL PLANS

Base plan (Please check the plan you would like and write in the selected plan name.)

☐ Traditional plan _____

☐ Deductible plan _____

☐ High deductible health plan (HSA-qualified) _____

☐ Kaiser Permanente Plus™ plan _____

☐ Kaiser Permanente Plus™ deductible plan _____

☐ Dual Choice PPO® plan _____

☐ Dual Choice PPO® HSA-qualified plan (HDHP) _____

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Plans and riders offered and underwritten by **KFHPNW** *continued*

☐ Added Choice® plan (point of service)[1] _____

☐ Added Choice® HSA-qualified plan (point of service HDHP)[1] _____

Do you have employees who both live and work outside our service area?[2] ☐ Yes ☐ No

☐ PPO Plus® plan[2] _____

☐ PPO Plus® HSA-qualified plan (HDHP)[2] _____

☐ Early retiree/employer-sponsored Senior Advantage _____

Riders (Please check each rider you wish to purchase and indicate the rider description [e.g., prescription plan $10/$20/$40/$150].)

☐ Outpatient prescription drug _____

☐ Supplemental tier for preventive drugs (non-ACA) _____

☐ Alternative care (Oregon) _____

☐ Massage therapy (Washington) _____

☐ Fertility treatment _____

☐ Hearing aid (Oregon) _____

☐ Pediatric vision hardware and optical services _____

☐ Pediatric vision hardware and optical services enhanced benefit (Oregon)[3] _____

☐ Adult vision hardware and optical services _____

☐ Dental accidental injury (Oregon) _____

☐ Travel immunizations (excludes PPO Plus) _____

Medical plan accumulation (out-of-pocket expenses, applicable deductibles, and benefit limits)
☐ Calendar year ☐ Plan year (not common)

Note any reimbursements you provide your employees toward their deductible, copays, and coinsurance. Be specific as to reimbursement annual maximum and what cost shares it applies toward:

_____

IMPORTANT: You must attach a copy of all selected proposals and return them with this form.

DENTAL PLANS

Base plan (Please check the plan you would like and write in the selected plan name.)

☐ Traditional Dental plan _____

☐ PPO Dental plan _____

Riders ☐ Dental office copay (traditional plans only) _____ ☐ Deductible (individual/family) _____

☐ Dental orthodontics rider _____

☐ Dental implant rider _____

[1]Added Choice plans are only available for renewing groups and groups with 500+ eligible employees.
[2]For Washington-situs groups, if you have employees who both live and work outside Clark and Cowlitz counties, they must be enrolled in a PPO Plus out-of-area plan.
[3]Not available with Dual Choice PPO, Added Choice, or PPO Plus plans.

Section II: Premium and eligibility[1]

Plan premium rates
(Please write the plan name and premium rates for each premium tier and each plan below.)

Plan name					
Employee					
Employee/Spouse/ Domestic partner[2]					
Employee/Family					
Employee/Child(ren)					

Do your eligibility rules allow for mid-month effective dates? ☐ Yes ☐ No

If effective date is other than first of the month for new eligibility or end of the month for terminations, please select payment rule based on eligibility:

☐ Enrolled or termed 1st–31st and full premiums.

☐ Enrolled 1st–31st full premiums. Termed 1st–15th pay $0 premiums, termed 16th–31st full premiums.

☐ Enrolled 1st–15th full premium, 16th–31st $0 premiums. Termed 1st–31st full premiums.

☐ Enrolled 1st–15th full premium, 16th–31st $0 premiums. Termed 1st–15th $0 premiums, termed 16th–31st full premiums.

☐ Premium prorate

☐ Other (requires approval): _____

[1]For the state of Washington, if you use a Custom Employee Enrollment Application, Kaiser Foundation Health Plan of the Northwest must receive an electronic copy. Custom Employee Enrollment Applications must meet all state requirements and be filed with the state by Kaiser Foundation Health Plan of the Northwest.
[2]A person who is legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Oregon or Washington, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.

Representation regarding waiting periods
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 Company 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.

Termination processing
☐ Last day of the month following or coinciding with eligibility end date
☐ Date eligibility ends

Overage dependent limiting age (cannot be under 26)

To _____ years

Overage student limiting age (cannot be under 26)

To _____ years

This plan will cover
☐ Employees and dependents
☐ Employees only
☐ Surviving dependents
☐ Special eligibility
_____
(requires approval)

Domestic partner coverage (non-state registered)? ☐ Yes ☐ No

As required by state law, coverage for state registered domestic partners is included in all group plans when dependents are covered. 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 for non-state registered domestic partners. If "Yes" is selected above, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

Number of eligible employees	Number of ineligible employees and full-time equivalents	Total number of employees
_____	_____	_____

Section III: Employer information ☐ No change

Type of business	NAIC code (required)	Tax identification number

Please check all that apply:

☐ Publicly traded corporation
☐ Privately held corporation
☐ State government
☐ Local government
☐ Church group
☐ Corporation
☐ Partnership
☐ Limited partnership
☐ Proprietor
☐ Not-for-profit
☐ Control group
☐ Other

In business since

Do you have workers who are independent contractors or who do seasonal work? ☐ Yes ☐ No

Group plan sponsor

☐ Association ☐ Employer ☐ Labor organization
☐ Trustees or fund established by one or more employers or labor organizations

Is the business a branch office? ☐ Yes ☐ No	Is the business a subsidiary? ☐ Yes ☐ No

Group administrator/primary contact

Name			
Address	City	State	ZIP
Email	Telephone	Fax	
Billing name Billing address	City	State	ZIP
Email	Telephone	Fax	
Corporate headquarters address (if different from above)	City	State	ZIP

Has your firm ever contracted with KFHPNW? ☐ Yes ☐ No
If so, what was the legal name of the contracting firm? _____
Dates of previous contract with KFHPNW _____

Are your benefit plans subject to the ERISA claim regulations issued by the U.S. Department of Labor?
☐ Yes ☐ No

Third-party administrator for COBRA enrollment/billing (if applicable)			
Name			
Address	City	State	ZIP
Email	Telephone	Fax	

Section IV: Insurance information (prior to this contract) ☐ No change

Workers' compensation/state industrial carrier	Policy number(s)		
Current health insurance carrier	Policy number(s)		
Address	City	State	ZIP
Current dental insurance carrier	Policy number(s)		
Open enrollment period _____ through _____	Effective date		
Renewal notification ☐ 90 days ☐ 120 days ☐ Other (how many days?) _____ (requires approval)			
Do any of your employees have Medicare? ☐ Yes ☐ No	If retirees are 65 or older, how is your retirement drug plan set up?		
Retiree eligibility age ☐ No retirement plan offered ☐ Younger than 65 ☐ 65 or older	☐ Medicare Part D ☐ Retiree Drug Subsidy (RDS) ☐ Other		

Section V: Multiple carrier requirements and contractual provisions

Multiple carrier offering

Is KFHPNW the only medical and/or dental carrier offered by the group? ☐ Yes ☐ No

If no, complete the following information:

Name of other carrier _____

Number of employees enrolled with other carrier _____

Name of other carrier _____

Number of employees enrolled with other carrier _____

Section VI: Employer contribution (upon effective date of this contract)

The group will contribute the following amounts of the monthly premium. If different employee classes are chosen, please indicate the contribution for each class. The minimum employer contribution amount is 50% of the employee premium for the lowest cost medical plan or (nonvoluntary) dental plan.

	Description	% or $ of employee premium	% or $ of dependent premium
Medical plan 1:			
Medical plan 2:			
Dental plan:			
Class of employee:			
Class of employee:			
Class of employee:			

For renewing groups, is this a change in the employer contribution percentages? ☐ Yes ☐ No

Section VII: Producer of record (agent) ☐ No change

Please complete this section if you are represented by one of our appointed health insurance producers.

Effective date _____, employer hereby appoints _____

producer of _____ (agency) as producer of record to represent the employer in matters of group health benefits provided by KFHPNW and/or its subsidiaries. This appointment rescinds all previous appointments and will remain in effect until terminated in writing by either party.

Producer may make requests concerning premiums, benefits, eligibility requirements, and other matters relating to health coverage. The employer understands that commissions due to the producer for services provided pursuant to the appointment are governed by an agreement between the producer and KFHPNW.

Producer phone number: _____ Producer email: _____

Producer/commission
Premiums include the following producer/commission level: _____% of premium.

Section VIII: Authorizing signature(s)

This form is not valid if selected proposals are not attached and if it is not signed.

I understand that if I have an authorized agent/broker/producer of record, then the agent/broker/producer 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/producer 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).

Authorized employer signature	Title	Date
Print name of principal/corporate officer	Title	Date
If you are a producer who completed this application on behalf of a client, please indicate so by signing.	Title/firm name	Date

For Washington state employers: You acknowledge by your signature that the information you have supplied on this form is true and correct. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If you use a custom enrollment application, it must meet requirements for Washington custom enrollment applications and we must receive an electronic copy of your enrollment application.

For Oregon state employers: You acknowledge by your signature that the information you have supplied on this form is true and correct. It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits. If you use a custom enrollment application, we must receive an electronic copy of your enrollment application.

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