KAISER PERMANENTE®

2024 Washington Small Group

EMPLOYER APPLICATION

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th Street, Renton, WA 98057.

Requested effective date ______ / ______ / ______

1 ABOUT BUSINESS

Legal business name (as stated on your local business license, quarterly wage and tax report, or corporate or partnership documents)

Doing business as (DBA)	Business website

Physical street address **(no P.O. boxes)**	City	State	ZIP	County

Phone
(   )   –

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

In business since (mm/dd/yyyy)	Federal tax ID (EIN) number	NAICS code (6 digits – visit **naics.com/search**)
/ /		

2 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 number and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal month:

3A 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 one employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No If *Yes*, please provide below:

Company name	☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal tax ID number	Phone ( ) –

Business name (please print): ____________________

3B EMPLOYEE COUNT

Please provide the total number of employees nationwide (full-time and part-time). To qualify for small group coverage, your company must have had at least one but no more than 50 employees on average during the previous calendar year.
Total ____________________

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible employees.** Total ____________

Please provide the total number of **enrolling employees.** Total ____________

Hours per week employees must work to be eligible for coverage: ____________

Are you offering dependent coverage?[1] ☐ Yes ☐ No

[1]If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980H(c)(2) of the Internal Revenue Code.

3D DOMESTIC PARTNER COVERAGE

Do you wish to offer non-state-registered domestic partner coverage? ☐ Yes ☐ No

See Domestic Partner Coverage in the Agreement and Signature section for state-registered and non-state-registered domestic partner coverage details.

4 CONTINUATION COVERAGE

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA? ☐ Yes ☐ No
Are you submitting COBRA applications? ☐ Yes ☐ No

5A ERISA STATUS

Is your company subject to ERISA?[2] ☐ Yes ☐ No If you do not select an answer, we'll record your status as *Yes*.

[2]ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally aren't. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

5B MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA?[3] ☐ Yes ☐ No

[3]If your company employed 20 or more full-time and/or part-time employees for each working date for 20 or more calendar weeks in the current calendar year or preceding calendar year, your group is subject to this federal law.

Business name (please print): ______________________________

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage or a fixed dollar amount. **Your minimum contribution must be at least 50% of the "employee only" monthly premium for the lowest-priced Kaiser Permanente medical plan offered by you, the employer.**

Percentage of the premium is based on the following **(select one only):**
☐ Lowest-priced plan offered ☐ All plans offered ☐ Specific plan offered: ______________

Employer contribution (50%-100%): __________ % per employee; __________ % per dependent **(optional)**

Employer contribution (fixed): $ __________ per employee; $ __________ per dependent **(optional)**

7A CONTRACT SIGNER

This person is responsible for receiving and providing renewal information and is authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business's physical address.

First name	MI	Last name	Title
Mailing address	City	State	ZIP
Office phone ( ) –	Ext.	Cellphone ( ) –	
Email	How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

7B BILLING CONTACT

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information. Only one billing contact is allowed.

☐ **Check here if same as contract signer.**

First name	MI	Last name	
Mailing address	City	State	ZIP
Office phone ( ) –	Ext.	Cellphone ( ) –	
Email	How should we correspond with this person? **(select one only)** ☐ Email ☐ Mail		

Business name (please print): ______________________________

8A MEDICAL PLANS

Select rating structure:

☐ **Age-banded rates** (or "list bill"). All individuals are charged based on the age band determined by their age at plan effective date. Age bands are 0 to 14, then by year from 15 to 63, and 64 or older. In each family, the 3 oldest children, up to age 20, are charged.

☐ **Composite rates** comprise 2 rates. One rate – for all enrollees 21 and older – is determined by their combined average age-banded rate. Another rate – for all enrollees 20 and younger – is determined by their combined average age-banded rate. In each family, the 3 oldest children, up to age 20, are charged.

Mix and match plans across our network options to find the best fit for your business:*

- Groups with 1 to 5 employees on payroll may offer up to 4 plans.
- Groups with 6 to 50 employees on payroll may offer any number of plans.
- Connect provider network plans are available only in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties.

* Employee-only (EO) contract plans can only be combined with other EO plans.

Kaiser Foundation Health Plan of Washington
Core provider network

☐ Bronze HSA
☐ Silver HSA
☐ Silver
☐ Core VisitsPlus Silver LX[3]
☐ Core VisitsPlus Silver LX[3] EO[1]
☐ Core VisitsPlus Gold HD[2] LX[3]
☐ Core VisitsPlus Gold LX[3]
☐ Core VisitsPlus Gold LX[3] EO[1]
☐ Core VisitsPlus Platinum LX[3]

[1] EO — Employee-only contract [2] HD — High deductible [3] LX — Lab and X-ray

Kaiser Foundation Health Plan of Washington
Connect provider network — available in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties.

☐ Virtual Plus Silver
☐ Virtual Plus Gold

Kaiser Foundation Health Plan of Washington Options, Inc.
Access PPO provider network

☐ Access PPO Bronze HSA
☐ Access PPO Silver HSA
☐ Access PPO VisitsPlus Silver HD[2]
☐ Access PPO VisitsPlus Silver LD[4] LX[3]
☐ Access PPO VisitsPlus Silver LX[3]
☐ Access PPO VisitsPlus Silver LX[3] EO[1]
☐ Access PPO VisitsPlus Gold LX[3]
☐ Access PPO VisitsPlus Gold HD[2] LX[3]
☐ Access PPO VisitsPlus Platinum HD[2] LX[3]
☐ Access PPO VisitsPlus Platinum LX[3]

[1] EO — Employee-only contract [2] HD — High deductible [3] LX — Lab and X-ray [4] LD — Low deductible

☐ Summit PPO Bronze HSA
☐ Summit PPO VisitsPlus Silver LX
☐ Summit PPO VisitsPlus Gold LX
☐ Summit PPO VisitsPlus Platinum LX

Business name (please print): ______________________________

8B DENTAL PLANS

Please select one of the optional dental plans for your employees and their dependents OR choose the mandated pediatric-only dental coverage. Dependents include spouse/domestic partners and dependent children 25 and younger.

- ☐ Small Group Standard Family Plan ($1,500 annual plan maximum)
- ☐ Small Group Basic Family Plan ($1,000 annual plan maximum)
- ☐ Pediatric Plan (This is required and must be added if no family dental plan is chosen. The Affordable Care Act mandates pediatric dental coverage for anyone 18 and younger enrolled in the medical plan.)

Note: Dental premiums for employees or applicable dependent enrollees 18 and younger will be assessed and billed separately from the medical premiums.

Coverage provided by Delta Dental of Washington, 400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371.

9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is only an application for coverage. No contract for coverage will exist until Kaiser Foundation Health Plan of Washington (KFHPWA) or Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO), has completed its review and communicated to the business applicant or the applicant's producer that the application has been accepted and a group health plan contract/group policy will be issued.

10 AUTHORIZED PRODUCER OF RECORD FOR KAISER PERMANENTE

To be completed by Producer.
To the best of my knowledge and belief, employment and other information on this application is complete and accurate. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of Kaiser Foundation Health Plan of Washington. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved. I understand that I have no right to bind this coverage or to alter terms of the insurance.

Primary (authorized producer)

Producer name	Percent split

Firm name	Kaiser Permanente producer firm ID

Producer signature	Date
X	

Secondary (only if adding another firm; doesn't apply to a second producer at the same firm)

Producer name	Percent split

Firm name	Kaiser Permanente producer firm ID

Business name (please print): ______________________________

11 AGREEMENT AND SIGNATURE

As a company principal/corporate officer having authority to contract with Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., I agree that:

- 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 application forms provided or approved by Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., for new employees.
- The eligibility data provided by my company to Kaiser Permanente 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 won't exceed the waiting period established by my company.
- Workers' compensation: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., does not cover work-related illness/injuries regardless if they have workers' compensation coverage or not.
- My company will abide by the contract provisions.
- Dependent children, if covered, are covered through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan.

I have read, understood, and agreed to Kaiser Permanente's Underwriting Guidelines, which may be included with my rate quote or, if not included, are available online.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I have a minimum of one W-2 employee (excluding the owner, spouse, or legal domestic partner) of a sole proprietorship or partnership. I attest that the minimum participation requirements are met.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/sbc**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

Domestic Partner Coverage

- As required by state law, coverage for state-registered 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 for non-state-registered domestic partners. 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 the law requires coverage of these individuals. Please seek guidance from your counsel on dependent coverage obligations.
- Washington state-registered domestic partners are treated the same as a spouse.

I understand that if I have an authorized producer of record, then the 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 group account will be granted to my 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.

(continues on next page)

KAISER PERMANENTE®

Business name (please print): ______________________________

Authorized representative certification

I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., will have the right to cancel the contract to the extent allowable under applicable federal and state law. Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., reserve the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

KFHPWA/KFHPWAO shall not rescind my plan contract/policy for any reason and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente plans X	Date

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