



NEW GROUP APPLICATION

This application for Kaiser Foundation Health Plan, Inc. (Health Plan), benefits is intended for the business(es) below. (Attach additional sheets if necessary.)

■ **Effective date** _____

Plan options effective January 1, 2007, through June 1, 2007

Please select the plan(s) you would like to offer. Check here if you are selecting two or more plans. Your group must have a minimum of three subscribers.¹

Copayment plans	<input type="checkbox"/> \$50 plan	<input type="checkbox"/> \$30 plan	<input type="checkbox"/> \$20 plan	<input type="checkbox"/> \$15 plan	<input type="checkbox"/> \$5 plan
Deductible plans	<input type="checkbox"/> \$30/\$1,500 plan ¹ (only available with a multiple plan offering)	<input type="checkbox"/> \$30/\$1,000 plan	<input type="checkbox"/> \$40/\$1,000 plan		
Deductible plans with HSA option	<input type="checkbox"/> \$30/\$2,700 plan with HSA	<input type="checkbox"/> \$0/\$2,700 plan with HSA	<input type="checkbox"/> \$0/\$1,500 plan with HSA		
Deductible plans with HRA	<input type="checkbox"/> \$30/\$2,500 plan with HRA	<input type="checkbox"/> \$30/\$1,500 plan with HRA			

Point-of-service plans	<input type="checkbox"/> \$35 POS Plan ^{1,2} (only available with a multiple plan offering)	<input type="checkbox"/> POS Plan with Infertility ^{1,2}
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I want to offer my employees dental and/or chiropractic coverage.

Dental option	Add fee-for-service dental plan	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E	<input type="checkbox"/> Plan E with Ortho (requires at least 25 subscribers)
	Add PPO dental plan	<input type="checkbox"/> PPO D 1500	<input type="checkbox"/> PPO E 1000	<input type="checkbox"/> PPO E 1500	
Chiropractic option	<input type="checkbox"/> Add chiropractic option				

The traditional HMO plan and the in-network portion of the point-of-service (POS) plans are underwritten by the Health Plan. Kaiser Permanente Insurance Company (KPIC) underwrites the out-of-network portion of the POS plans and the dental plans. KPIC is a subsidiary of the Health Plan.

Business information

Business name _____

Address (in California) _____ City _____ State _____ ZIP _____

() _____ () _____
Phone _____ Fax _____ E-mail _____

(By giving Kaiser Permanente your fax number and e-mail address, you agree to receive faxes and e-mail from us.)

Type of business: Corporation Partnership Sole proprietor Other _____

SIC/NASIC code _____ In business since _____

Have you had previous small business group insurance through Kaiser Permanente? Yes No If yes, group number _____

Is your company currently active with another health insurance carrier? Yes No If yes, name of other carrier _____

Will you be offering another carrier's health care plans to your employees? Yes No If yes, name of health care plan carrier _____

Number of employees enrolled _____

Number of COBRA or Cal-COBRA enrollees (applying for health coverage) _____

What type of continuation coverage are you subject to? Federal COBRA Cal-COBRA

If federal COBRA, how would you like your COBRA enrollees to be billed? Group-billed or third-party administrator Kaiser Permanente-billed

Do you have workers' compensation coverage? Yes No If yes, name of carrier _____

¹ **Forthose choosing a multiple plan offering:** Your group must have a minimum of three subscribers. You may choose one or more copayment plans but only one deductible plan. The \$30/\$1,500 Deductible Plan and the \$35 POS Plan are only available with a multiple plan offering. Your group may be subject to recertification upon renewal.

²For your group to be eligible for the \$35 POS Plan, Kaiser Permanente must be your sole carrier.

Business name _____

NEW GROUP CHECKLIST

Easy steps to enrollment

To help us process your enrollment accurately, please be sure all the items listed below are completed and submitted to your broker before the effective date of coverage.

New Group Application

- The application must be completed, including the signature of the owner and date of signature.
- If the application is submitted without your signature, it will be returned, delaying implementation of your group's coverage.
- Make sure that all broker information is completed.

Employee application

If your group is enrolling in a copayment or deductible plan, it is very important that you communicate the type of plan and plan name to your employees. They will need to check the plan name in the following places:

- 1) on the cover of their enrollment booklets, in order to reference information about their benefits, and
- 2) on their *Temporary Membership ID Form*, which is located in the employee enrollment booklet.

Make sure all employees complete, sign, and date an enrollment form located in the employee enrollment booklet. The form must include the following:

- Company name
- New purchaser box checked
- Social Security numbers and dates of birth of family members to be included in the coverage
- A completed *Student Certification Form* for dependents who are 19 to 24 years old
- Employee's/Subscriber's signature on the application

Declination of coverage

All eligible employees who are refusing coverage must complete the *Declination of Coverage Form*. A minimum of 70 percent of all eligible employees must have group coverage.

Initial premium check

A copy of a business check in the amount of the first month's premium must be submitted as a deposit. Please make the check payable to Kaiser Permanente. Once the group is approved, a mailing address will be provided for submitting the original check.

Proprietor/Partner/Corporate Officer Form

Must be completed for each proprietor/partner/corporate officer enrolling not listed on the DE 6 or payroll report

Owner-only groups

Owner-only groups enrolling, such as a husband and wife enrolling with or without children, must qualify as a business by providing the *Proprietor/Partner/Corporate Officer Form* and one document, including but not limited to the following:

- Business license
- DBA fictitious name statement
- Contractor's license
- Seller's permit

Sole proprietorship

If co-owner is a spouse and is not listed, the following must be submitted, along with the *Proprietor/Partner/Corporate Officer Form*:

- 1040 Schedule C for the preceding calendar year
- One of the eligibility documents listed under the "Owner-only groups" section

Corporations

For corporations, submit at least one of the bulleted documents listed below, plus the business license and the *Proprietor/Partner/Corporate Officer Form*:

- Articles of incorporation (state seal affixed) including officers and Schedule K-1
- Statement of Information by Domestic Stock Corporation
- Shareholder/Stock certificates
- Tax form 1120 or 2553

DE 6 (Quarterly Wage Report) or payroll report

- Most recent DE 6 or payroll report will be required for each employee for verification of eligibility
- DE 6 from the previous quarter (notate updated employee status, i.e., part-time, full-time, or terminated, and name of other carrier if the employee has other group coverage)
- Payroll records for employees hired after the DE 6 filing
- Proof of owner's/employer's eligibility, if the owner/ employer is not listed on the DE 6 (See *Proprietor/ Partner/Corporate Officer Form* section.)
- A copy of the Employment Development Department (EDD) response letter or application is required if the company recently established payroll. (If the EDD letter or application is not available, a second document may be required. See "Owner-only groups" section.) Note: The DE 6 will suffice by itself if the owners and all employees enrolling in the plan are listed, and as long as Kaiser Permanente can verify the business. If not, Kaiser Permanente will require a second document, such as a business license or articles of incorporation.

Submit enrollment materials

Fax is the preferred method for submitting the enrollment materials. Fax to **1-800-369-8010**.

Business name _____

Principal owners/Corporate officers

1. Name _____ Title _____ Social Security number/EIN _____

2. Name _____ Title _____ Social Security number/EIN _____

■ Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under the Health Plan.

■ How long must a new hire be employed before being offered health care benefits? **Benefits are effective the first of the month following the waiting period.** (Check one.) Date of hire 30 days 60 days 90 days 180 days 365 days

■ Billing statements to be mailed to (person/title) _____ Address _____ City _____ State _____ ZIP _____

■ Contract to be mailed to (person/title) _____ Address _____ City _____ State _____ ZIP _____
 Check here if this person is authorized to make changes to your contract.

■ Interested party (An interested party is authorized to access information about your account.) _____

Please complete, sign, and date below. I authorize the following individual to act as broker of record for Kaiser Foundation Health Plan, Inc.

Broker name _____ Firm name _____

Broker address _____ City _____ State _____ ZIP _____

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Phone _____ Fax _____

California L&D license # _____ Expiration date _____ Kaiser Permanente broker ID # _____

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc., I agree that my company will contribute at least 50 percent of the employee-only rate for the under-30 age band for each subscriber, that our prepaid monthly premiums will be submitted by the fifth of each month prior to the month of coverage, that my company will use enrollment application forms that are provided or approved by the Health Plan, and that my company will abide by the contract provisions. I understand that the broker of record may receive monetary and/or nonmonetary payments from the Health Plan and/or KPIC in connection with the purchase of this health plan coverage.

Note: Binding arbitration does not apply to disputes with KPIC or disputes with out-of-network providers.

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for small claims court cases, claims subject to a Medicare appeals procedure, and, if my group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

X _____
Employer signature _____ Title _____ Date _____