



**KAISER PERMANENTE®**

**SMALL GROUP EMPLOYER APPLICATION**  
(FOR GROUPS WITH 2-50 ELIGIBLE FULL-TIME EMPLOYEES)

This form must be completed and signed by the employer. This application is subject to review and approval by the Health Plan and/or KPIC, as applicable.

Please Note: Statements made in the application form are deemed representations and not warranties.

**Section 1. Employer Information**

\_\_\_\_\_  
Firm Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
County Tax ID #

\_\_\_\_\_  
SIC Code

\_\_\_\_\_  
Billing Address, if different from the above

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

Key Contact (person to whom correspondence should be directed at employer's place of business)

\_\_\_\_\_  
First & Last Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Describe nature of business, including primary services and products.

\_\_\_\_\_  
E-mail Address

Corporation  Partnership  Proprietorship

Number of years in business \_\_\_\_\_

**Section 2. Prior Coverage**

Is this application made to replace any existing group insurance?

Yes  No

Name of existing or prior group insurance carrier:  
\_\_\_\_\_

Number of insurance carriers your group has been insured with in the past three years: \_\_\_\_\_

Policy number or case number of prior or existing group insurance: \_\_\_\_\_

Has group had prior coverage within last 12 months?

Yes  No

Date prior coverage terminated (mm/dd/yy) \_\_\_\_ \_\_\_\_ \_\_\_\_

A copy of your most recent billing statement must be submitted with this application.

### Section 3. Eligibility

Effective date desired (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_

(In no instance may coverage be backdated.)

Present eligible, full-time employees to be insured:

Immediately, subject to approval by Health Plan and/or KPIC, as applicable

The first of the month following \_\_\_\_\_ days from the first day of work (waiting period).

Future eligible full-time employees will be eligible to be insured the first day of the month following \_\_\_\_\_ days from the first day of work (minimum 30 days). Employees who are eligible to be insured at the time of employer's original enrollment and who are approved by Health Plan and/or KPIC, as applicable will be insured on the effective date specified above in this agreement, if approved by the Health Plan and/or KPIC, as applicable. All other full-time employees may be eligible to be insured the first of the month after the waiting period expires. The effective date will be the first of the month following receipt and approval by Health Plan and/or KPIC, as applicable of sign-ed and properly completed *Employee Enrollment Application and Change Form* and such additional information as may be required. All employees and dependents who are not original enrollees are subject to the requirements and conditions specified in the administrative information which will be sent to the employer upon approval and issuance of coverage by Health Plan and/or KPIC, as applicable.

Health Plan and/or KPIC, as applicable reserves the right to require such additional information including medical records and questionnaires that it deems necessary before approving and issuing any coverage for any present or future employee or dependents.

Total number of eligible, full-time employees: \_\_\_\_\_

Number of eligible, full-time employees applying for coverage: \_\_\_\_\_

Total number of ineligible part-time employees: \_\_\_\_\_

Number of eligible full-time employees waiving coverage: \_\_\_\_\_

Has anyone in your group currently exercised their rights under COBRA, is currently totally disabled, on disability retirement, or extended sick leave?

No  Yes

\_\_\_\_\_  
Name

Does your company have separate locations, affiliates, or subsidiaries?

No  Yes Please list them below:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Location

Number of employees \_\_\_\_\_

Number covered on this plan \_\_\_\_\_

If there are additional addresses, please list them on a separate sheet.

### Section 4. Agreements

The undersigned employer hereby certifies that the firm indicated employs \_\_\_\_\_ full-time (equivalent to 30 hours per week or more) employees and that no part-time employees have been included for coverage. The employer agrees to contribute toward the premium cost the following percentages: \_\_\_\_\_ % for employees, \_\_\_\_\_ % for dependents. The employer must contribute a minimum 50% (groups of 6-50 eligible employees) or 75% (groups of 2-5 eligible employees) toward the employee portion of monthly premium. The employer understands the licensed broker, if any, who solicited this application was acting as an independent contractor and not as a broker of the Health Plan and/or KPIC, as applicable. Furthermore, the broker who solicited this agreement or upon whose explanation of coverage and benefits employer relied is in fact employer's broker for purposes of this agreement. It is understood that as an independent contractor and as employer's broker that person has no right to bind this coverage or to alter terms or conditions of any policies or any enrollment applications or to waive any requirements of Health Plan and/or KPIC, as applicable or to adjust any claims for benefits under this

insurance for which employer is applying. The employer acknowledges and agrees that: coverage under any policy will only be as and to the extent provided and it is employer's duty and responsibility to explain this to each person for whom coverage is sought. Employer has reviewed the benefits and limitations of coverage in the benefits summary and has explained such benefits and limitations to each person for whom coverage is sought. It is also acknowledged and agreed that coverage will begin only: (1) if this agreement is approved by Health Plan and/or KPIC, as applicable, (2) if written notice of approval is received by employer, and (3) upon the effective date inserted by Health Plan and/or KPIC, as applicable in the approval form and in the written notice of approval to employer. The absence of written approval will not imply approval.

Employer may cancel this agreement at any time upon 30 days prior written notice to Health Plan and/or KPIC, as applicable. For the duration of coverage, employer agrees to pay premiums on a monthly basis or at such other frequency as agreed upon by Health Plan and/or KPIC, as applicable. If Health Plan and/or KPIC, as applicable does not receive payment in full within the time allowed, this will automatically constitute with-

drawal and cancellation of all coverage. The effective date of coverage termination will be 12:01 a.m. of the first day of the billing period for which the premium was not paid when due if: (1) coverage is terminated because of nonpayment of premium in full; or (2) employer has not given prior written notice of cancellation. Coverage for the participating employees and their dependents will be continuous unless (1) the employee terminates employment; (2) the employee or dependent ceases to be eligible; or (3) requirements of this agreement are not maintained by the participating parties hereunder, including employer and employees. Employer agrees that the terms and benefits of the policies may be amended, modified, or changed at any time upon 60 days prior notice to employer. The employer is establishing this plan to provide medical and

other benefits to its eligible employees and dependents. Employer acknowledges that this plan constitutes an employee welfare benefit plan and agrees, as "sponsor", to fully comply with the applicable provisions and requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Employer designates Health Plan and/or KPIC, as applicable, as the named fiduciary for claims and appeals arising under the Group Agreement and/or Group Policy, as applicable. Neither Health Plan nor KPIC is the administrator of employer's employee benefit plan as that term is defined under ERISA. This provision only applies to an employer who sponsors an employee welfare benefit plan covered by ERISA, and where Health Plan's and/or KPIC's group health coverage is a component of that employee welfare benefit plan.

**[Section 5. Benefits desired]**

<input type="checkbox"/> Single Option]	<u>[HMO PLANS</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Plan F]	<u>[PRESCRIPTION DRUG COVERAGE</u> <input type="checkbox"/> \$15/\$25 <input type="checkbox"/> \$20/\$30]	<u>[MULTI-CHOICE PLANS</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan H <input type="checkbox"/> Plan I]	<u>[MULTI-CHOICE VALUE PLANS</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E]		<u>[OUT-OF-AREA PPO PLANS</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E]
<u>DEDUCTIBLE PLAN WITH HSA OPTION</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D				<u>[MULTI-CHOICE WITH HSA OPTION</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E]	<u>[OUT-OF-AREA PPO WITH HSA OPTION</u> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D]	

HMO plans (including Deductible Plans), and the [Select provider] benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). The [PPO provider and Non-participating provider] benefit levels of the Multi-Choice plans and Out-of-Area Indemnity plans are underwritten by Kaiser Permanente Insurance Company (KPIC).

**[Section 6. Request for coverage]**

We hereby apply for the group benefits set forth in the benefit summary brochure. We understand that the following conditions must be met before insurance becomes effective, and must continue to be met. To be eligible:

- 1) Employees must be full-time, earning compensation equal to a minimum of the Federal minimum wage for 30 hours per week or more.
- 2) This agreement must be accepted and approved in writing by Health Plan and/or KPIC, as applicable.
- 3) The following enrollment percentages must be met and continuously maintained:
  - Firms with two or three eligible employees must maintain 100% participation for health coverage of all eligible employees.
  - Firms with four through 50 eligible employees must maintain 75% participation for health coverage of all eligible employees.

Any employees who are covered for health care under Champus/Champva, Medicare or their spouse's group cover-

age may waive health coverage. The participation schedule would apply to the remaining eligible employees. The employer will (1) maintain the records necessary to the administration of the agreement; (2) report additions, changes, terminations and other information necessary to the administration of the agreement to Health Plan and/or KPIC, as applicable within 30 days after the effective date of such additions, changes and terminations; (3) agree that if employer does not notify Health Plan and/or KPIC, as applicable of any insured ineligibility or termination within 30 days, shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax return, and personnel files and other documentation as determined by the Health Plan and/or KPIC, as applicable available upon request to the Health Plan and/or KPIC, as applicable or its authorized representative; (5) pay all premiums in accordance with the terms of this agreement; and (6) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate premium.

**[Section 7. Signature]**

All statements provided in this agreement are true, correct, complete, and within our personal knowledge. We have read and understood this agreement. We understand and agree that this agreement will become binding between Health Plan and/or KPIC, as applicable and us only upon acceptance by Health Plan and/or KPIC, as applicable. The absence of written approval will not imply approval. Any intentional material misstatement or incomplete statement of fact will be deemed a misrepresentation and will result in termination of all coverage with respect to us, our participating employees and their dependents without liability to the insurer.

Signed this \_\_\_\_\_ day of \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

By (Signature of Authorized Company Officer)

Title \_\_\_\_\_

Premium deposit collected: \$ \_\_\_\_\_

Authentication Code for CAS  
(Any 4 to 10 letters and/or numbers)

Name of Employer

Witness (Signature of Licensed Broker)

Please Print Broker Name

**For Health Plan and/or KPIC, as applicable, Use Only:**

Approved by

Date Month/Day/Year

Effective Date Month/Day/Year

**[Section 8. Writing Broker Information]**

(Please check box if this is to replace address currently on file.)

Writing Broker's Name

Street Address

Area Code Telephone Number

Fax

Mailing Address

State Zip

Social Security Number or Tax I.D. Number

Broker's E-mail Address

Broker's License: State License Number

**Broker's Statement:**

To the best of my knowledge and belief, all medical history, employment, and other information supplied in the group enrollment application is true and complete. 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 or KPIC. 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 concerning incomplete or additional underwriting information.

By (Writing Broker's Signature)

Date Month/Day/Year

