

2021 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	

States in which coverage is offered 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**

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) _____
- Dual Choice PPO™* _____
- Dual Choice PPO™ HSA-qualified plan* _____

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*For Oregon employer groups, with effective dates starting July 1, 2021, or later.

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

Added Choice® HDHP plan (HSA-qualified)¹ _____

Added Choice® plan (point of service)¹ _____

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

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

PPO Plus® plan² _____

Traditional Dental plan _____

PPO Dental plan _____

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].)

Prescription drug rider _____

Alternative care rider _____

Infertility treatment rider _____

Hearing aid rider _____

Pediatric vision hardware rider (Oregon) _____

Adult vision hardware rider _____

Dental orthodontics rider _____

Dental implant rider _____

Medical plan accumulation (out-of-pocket expenses, applicable deductibles, and benefit limits)

Calendar year Plan year

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

¹Only for renewing groups and groups with 500+ eligible employees

²For Washington groups, if you have employees who both live and work outside our service area, they will be enrolled in a PPO Plus plan.

Section II: Premium and eligibility¹

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 select payment rule (see section V):

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): _____

¹If you use a Custom Employee Enrollment Application, Kaiser Foundation Health Plan of the Northwest must receive an electronic copy. For the state of Washington, Custom Employee Enrollment Applications must meet all state requirements and be filed with the state by Kaiser Foundation Health Plan of the Northwest.

²A 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.

<p>How many hours per week must employees work to be eligible for health care coverage? _____</p> <p>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.</p> <p>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.</p> <p>Termination processing <input type="checkbox"/> Last day of the month following or coinciding with eligibility end date <input type="checkbox"/> Date eligibility ends</p>	<p>Overage dependent limiting age (cannot be under 26) To _____ years</p> <p>Overage student limiting age (cannot be under 26) To _____ years</p>	
<p>This plan will cover <input type="checkbox"/> Employees and dependents <input type="checkbox"/> Employees only <input type="checkbox"/> Surviving dependents <input type="checkbox"/> Special eligibility _____ (requires approval)</p>	<p>Domestic partner coverage (non-state registered)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.</p> <p>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.</p>	
<p>Number of eligible employees _____</p>	<p>Number of ineligible employees and full-time equivalents _____</p>	<p>Total number of employees _____</p>

Section III: Employer information

■ No change

Type of business		NAIC code (required)	Tax identification number	
Please check all that apply: <input type="checkbox"/> Publicly traded corporation <input type="checkbox"/> Privately held corporation <input type="checkbox"/> State government <input type="checkbox"/> Local government <input type="checkbox"/> Church group <input type="checkbox"/> Corporation				
<input type="checkbox"/> Partnership <input type="checkbox"/> Limited partnership <input type="checkbox"/> Proprietor <input type="checkbox"/> Not-for-profit <input type="checkbox"/> Control group <input type="checkbox"/> Other				
In business since				
Do you have workers who are independent contractors or who do seasonal work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Group plan sponsor <input type="checkbox"/> Association <input type="checkbox"/> Employer <input type="checkbox"/> Labor organization <input type="checkbox"/> Trustees or fund established by one or more employers or labor organizations				
Is the business a branch office? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is the business a subsidiary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group administrator/primary contact				
Name				
Address		City	State	ZIP
Email		Telephone	Fax	
Billing name		City	State	ZIP
Billing address				
Email		Telephone	Fax	
Corporate headquarters address (if different from above)		City	State	ZIP
Has your firm ever contracted with KFHPNW? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> Other (how many days?) _____ (requires approval)			
Do any of your employees have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If retirees are 65 or older, how is your retirement drug plan set up?		
Retiree eligibility age <input type="checkbox"/> No retirement plan offered <input type="checkbox"/> Younger than 65 <input type="checkbox"/> 65 or older	<input type="checkbox"/> Medicare Part D <input type="checkbox"/> Retiree Drug Subsidy (RDS) <input type="checkbox"/> Other		

Section V: Dual choice 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.

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.

