

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

Group number _____

Requested effective date ____ / ____ / ____

1 ABOUT BUSINESS

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

| | |
|-------------------------|---------|
| Doing business as (DBA) | Website |
|-------------------------|---------|

 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 to find your code) |
|---------------------------------------|-----------------------------|--|

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

| | |
|----------------|--------------|
| Phone () - | Fax () - |
|----------------|--------------|

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage if you don't have workers' compensation, unless you're exempt. I attest that the following information is correct.

 Yes, my company has workers' compensation. Pending

If **Yes** or **Pending**, name of carrier: _____ Policy # _____
 (indicate *unknown* or *pending* as applicable)

 Exempt from providing workers' compensation for the following reason: _____

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 customer ID and company name.

 Yes No Group #: _____ Company name: _____

Does your company currently have active group health coverage?

 Yes No Name of carrier: _____ Renewal date: ____ / ____ / ____

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

 Yes No Name of carrier: _____ **Number of employees enrolled:** _____

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 1 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 | <input type="checkbox"/> Affiliate <input type="checkbox"/> Subsidiary |
|--------------|--|

| | | | |
|---------|------|-------|-----|
| Address | City | State | ZIP |
|---------|------|-------|-----|

| | |
|-----------------------|----------------|
| Federal tax ID number | Phone () - |
|-----------------------|----------------|

Business name (please print): _____

3B EMPLOYEE COUNTPlease provide the total number of employees (**full-time and part-time**).

Total _____ Authorized company signer's initials _____

Please provide the total number of **full-time and full-time-equivalent employees** during the prior calendar year on the line below. For information on calculating the number of full-time and full-time-equivalent employees, refer to **HealthCare.gov** or your legal counsel. (See Section 15, "Determining Group Size Under Oregon Law.") To qualify for small group coverage, your company must have at least 1 but no more than 50 full-time and full-time-equivalent employees during the prior calendar year.

Total _____ Authorized company signer's initials _____

3C ELIGIBLE AND ENROLLING EMPLOYEESPlease provide the total number of **eligible employees**. Total _____ Authorized company signer's initials _____Please provide the total number of **enrolling employees**. Total _____ Authorized company signer's initials _____

If you're covering only a certain class of employees, specify the class(es) you're covering: _____

Total number of employees eligible for Medicare coverage: _____

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

Employee only coverage?¹ Yes No

¹If 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 4980(H)(C)(2) of the Internal Revenue Code.

4 DOMESTIC PARTNER COVERAGEDo you wish to offer 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.

Additionally, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis.

5 CONTINUATION COVERAGEDid 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**6 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.

²ERISA 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.

7 MEDICARE SECONDARY PAYOR STATUSAre you subject to TEFRA?³ Yes No

³If 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): _____

8 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 1 only)**:

 Lowest 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)**
9 CONTRACT SIGNER INFORMATION

There's only 1 contract signer. This principal person is responsible for signing the group agreement, providing renewal information, and authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business physical address.

| | | | | | |
|----------------------------------|------|--|--------------------|-------|-------|
| First name | | MI | Last name | | Title |
| Street address (mailing address) | | | City | State | ZIP |
| Office phone () - | Ext. | Fax () - | Cellphone () - | | |
| Email | | How should we correspond with this person? (select 1 only) <input type="checkbox"/> Email <input type="checkbox"/> Mail | | | |

10 BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information, but isn't authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed.

 Check here if same as contract signer.

| | | | | | |
|-----------------------|------|--|--------------------|-------|-----|
| First name | | MI | Last name | | |
| Street address | | | City | State | ZIP |
| Office phone () - | Ext. | Fax () - | Cellphone () - | | |
| Email | | How should we correspond with this person? (select 1 only) <input type="checkbox"/> Email <input type="checkbox"/> Mail | | | |

Business name (please print): _____

11 SELECT BENEFIT OFFERINGS

Please indicate below if you'll offer a single plan or bundled plans. When bundling medical plans, please note that you can choose no more than 1 Added Choice® plan. When bundling family dental plans, please note you can only choose 1 traditional and 1 Dental Choice (PPO) plan. Indicate which specific plan or plans you wish to offer along with any dental plan(s). If you're offering different plans to different classes of employees, please provide details of plan offerings in the comments section.

Buy-up options — Any of the medical plans can be paired with an adult vision and/or alternative care buy-up option listed below, with the exception of the Standard plans. When selecting a plan with one of these buy-up benefit options, please check the appropriate box next to your medical plan selection.

Vision — \$200/2 years adult vision hardware benefit and vision exam

Alternative care — \$20 copay chiropractic, acupuncture/\$25 copay massage with a 12-visit limit per calendar year/\$1,000 benefit maximum for all services combined (subject to deductible on HSA-qualified high deductible health plans)

| | Medical plan | Buy-up option | | | HSA/HRA/FSA Selection(s) |
|----------|--------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Vision | Alt Care | Both | |
| 1st plan | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2nd plan | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3rd plan | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| | Dental plan |
|----------|-------------|
| 1st plan | |
| 2nd plan | |

12 PEDIATRIC DENTAL PLAN OPTIONS (Oregon Health Insurance Marketplace-certified)

We're required to include Oregon Health Insurance Marketplace-certified pediatric dental benefits with your medical plan(s). By enrolling in a Kaiser Permanente Small Business Medical Plan, each employee and each of his/her dependents will also be enrolled in a separate Oregon Health Insurance Marketplace-certified pediatric dental plan unless you've purchased other pediatric dental coverage certified by Oregon Health Insurance Marketplace. Employees won't be charged for pediatric dental coverage unless they have eligible children on the plan.

Please select your requested pediatric dental plan from the choices below.

We understand you may have acquired pediatric dental coverage from another carrier. Please select a plan in order to cover employees and/or dependents who may waive the alternate coverage. If no attestation is provided and no plan is selected, we will enroll your group in a default pediatric dental plan.

Traditional Plan Options:

- KP OR Traditional 80 Pediatric Dental Plan
- KP OR Traditional 100 Pediatric Dental Plan
- KP OR Traditional 100 + Ortho Pediatric Dental Plan

Choice Plan Options:

- KP OR Choice 80 Pediatric Dental Plan
- KP OR Choice 100 Pediatric Dental Plan
- KP OR Choice 100 + Ortho Pediatric Dental Plan

If you've already acquired pediatric dental coverage from another carrier, we'll rely on your confirmation.

- Enroll my group in the pediatric dental plan along with the Small Business Medical Plan that I have chosen.
- I have purchased pediatric dental coverage with another carrier.

Business name (please print): _____

13A MEDICAL PLANS
Medical plan options

| | | | |
|---|---|--|--|
| Traditional Plans | The following consumer-directed health plans are available with traditional plans: FSA. KP OR Platinum 0/20 KP OR Gold 0/30 | | |
| Deductible Plans | The following consumer-directed health plans are available with deductible plans: HRA, FSA, stacked HRA/FSA. KP OR Platinum 250/20 KP OR Gold 2000/40 KP OR Silver 5500/50 KP OR Platinum 500/20 KP OR Silver 2500/45 KP OR Bronze 7000/50 KP OR Gold 1000/20 KP Oregon Standard Silver KP OR Bronze 8550/40 KP Oregon Standard Gold KP OR Silver 3500/40 KP Oregon Standard Bronze KP OR Gold 1500/35 KP OR Silver 4500/45 | | |
| HSA-Qualified High Deductible Health Plans | The following consumer-directed health plans are available with the high deductible health plans: HRA, HSA, FSA, stacked HRA/FSA. KP OR Silver 2800/25% HSA KP OR Bronze 6900/0% HSA | | |
| Added Choice® Deductible Plans | The following consumer-directed health plans are available with Added Choice deductible plans: HRA, FSA, stacked HRA/FSA. KP OR Platinum 250/20 3T POS KP OR Gold 500/35 3T POS-00A* KP OR Silver 2500/45 3T POS KP OR Platinum 250/20 3T POS-00A* KP OR Gold 1000/20 3T POS KP OR Silver 2500/45 3T POS-00A* KP OR Gold 500/35 3T POS KP OR Gold 1000/35 3T POS-00A* 00A* | | |

*POS-00A plans: If you have employees who both live and work outside our service area, we may be able to set them up on an Added Choice out-of-area plan. Rates and approval subject to approval by underwriting. Group must meet underwriting requirements to purchase.

13B FAMILY DENTAL PLANS
Family dental plan options (these stand-alone dental plans are available Outside Market only)

| | | | |
|----------------------------|--|---|---|
| Traditional | KP OR Family Traditional 80 — \$1000 Max KP OR Family Traditional 80 — \$50 Ded/\$1000 Max KP OR Family Traditional 80 — \$100 Ded/\$1000 Max KP OR Family Traditional 80 — \$1000 Max + Ortho KP OR Family Traditional 100 — \$1000 Max KP OR Family Traditional 100 — \$50 Ded/\$1000 Max KP OR Family Traditional 100 — \$100 Ded/\$1000 Max KP OR Family Traditional 100 — \$1000 Max + Ortho | KP OR Family Traditional 100 — \$1500 Max KP OR Family Traditional 100 — \$50 Ded/\$1500 Max KP OR Family Traditional 100 — \$100 Ded/\$1500 Max KP OR Family Traditional 100 — \$1500 Max + Ortho KP OR Family Traditional 100 — \$2000 Max KP OR Family Traditional 100 — \$50 Ded/\$2000 Max KP OR Family Traditional 100 — \$100 Ded/\$2000 Max KP OR Family Traditional 100 — \$100 Ded/\$2000 Max + Implants | KP OR Family Traditional 100 — \$2000 Max + Ortho KP OR Family Traditional 100 — \$2000 Max + Ortho + Implants KP OR Family Traditional 100 — \$50 Ded/\$2500 Max KP OR Family Traditional 100 — \$100 Ded/\$2500 Max KP OR Family Traditional 100 — \$100 Ded/\$2500 Max + Implants KP OR Family Traditional 100 — \$2500 Max + Ortho KP OR Family Traditional 100 — \$2500 Max + Ortho + Implants |
| Dental Choice (PPO) | KP OR Family Choice 80 — \$50 Ded/\$1000 Max KP OR Family Choice 80 — \$100 Ded/\$1000 Max KP OR Family Choice 80 — \$1000 Max + Ortho KP OR Family Choice 100 — \$50 Ded/\$1000 Max KP OR Family Choice 100 — \$100 Ded/\$1000 Max | KP OR Family Choice 100 — \$1000 Max + Ortho KP OR Family Choice 100 — \$50 Ded/\$1500 Max KP OR Family Choice 100 — \$100 Ded/\$1500 Max KP OR Family Choice 100 — \$1500 Max + Ortho KP OR Family Choice 100 — \$50 Ded/\$2000 Max | KP OR Family Choice 100 — \$100 Ded/\$2000 Max KP OR Family Choice 100 — \$2000 Max + Ortho KP OR Family Choice 100 — \$50 Ded/\$2500 Max KP OR Family Choice 100 — \$100 Ded/\$2500 Max KP OR Family Choice 100 — \$2500 Max + Ortho |

Business name (please print): _____

14 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

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

15 DETERMINING GROUP SIZE UNDER OREGON LAW

Oregon Administrative Rule (OAR) 836-053-0015 establishes the method for defining a small employer. This rule and its Exhibit provide specific details about how to count employees toward the small and large group size thresholds. Generally speaking, a small employer in Oregon is one that employed (on average, during the prior calendar year) 1–50 full-time employees, including full-time-equivalent employees. A prescribed calculation determines the number of full-time and full-time-equivalent employees. Companies with a common owner or that are otherwise related under certain rules of Section 414 of the Internal Revenue Code are generally combined and treated as a single group.

To be considered a small employer under Oregon law (OAR 836-053-0015), the employer must employ at least 1 common law employee **who is enrolled on the plan at the beginning of the plan year.**

For more information on how to count employees toward the 1–50 threshold, which employees to count, and how to identify controlled groups, refer to any of these sources:

- OAR 836-053-0015 (find this OAR at <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=236678>)
- Exhibit A to OAR 836-053-0015 (find this Exhibit at https://dfr.oregon.gov/laws-rules/Documents/OAR/div53-0015_exA.pdf)
- IRS Publication, "Determining if an Employer is an Applicable Large Employer" www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer

You may also refer to **HealthCare.gov** or your legal counsel for information on calculating the number of full-time, full-time-equivalent, and eligible employees.

An employee is considered a common law employee if the employer has the authority to direct and control the manner in which the services are performed by the individual. For more information, see Exhibit A to OAR 836-053-0015 (search for exhibit at www.oregon.gov/DCBS).

Business name (please print): _____

16 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

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 KFHPNW. 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.

| | | | |
|------------------------------------|----------------------|----------------------------------|-----|
| Agent/broker name | | License number | |
| Phone () - | Fax () - | Cellphone () - | |
| Email | | | |
| Firm name | EIN/TIN | Kaiser Permanente broker firm ID | |
| Street address | City | State | ZIP |
| Agent/broker signature X | | Date | |

17 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHPNW, 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 KFHPNW 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.
- My company will abide by the contract provisions.

I have read, understood, and agreed to Kaiser Permanente's Rating and Underwriting Assumptions Policy, which may be included with my rate quote or, if not included, is available at 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 1 enrolling W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that the minimum participation requirement, based on group size: 1-50 eligible employees: 50% (valid waivers excluded) of eligible employees are covered by group coverage.

I attest that I have purchased pediatric dental coverage certified by Oregon Health Insurance Marketplace either through KFHPNW or through another carrier.

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

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. 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.

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