KAISER PERMANENTE®

Virginia Small Group
EMPLOYER APPLICATION

☐ **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street
Rockville, MD 20852

☐ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

Group number _____

Requested effective date ____/____/____

1 ABOUT BUSINESS

As checked above, application is made to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) and/or Kaiser Permanente Insurance Company (KPIC), collectively or individually referenced in this application as "Kaiser Permanente", "KFHP-MAS" or "KPIC".

Legal business name	Doing business as (DBA)

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

Phone	Fax
( ) –	( ) –

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 (5 digits)	Website
/ /			

All employees must be covered by workers' compensation, unless not required to be covered by law. You are not eligible to apply for coverage if you do not have workers' compensation, unless you are 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 group number and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier:

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 and must apply as 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	☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal tax ID number	Phone
	( ) –

3B EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Total _____

Note: If the total number of employees noted above is 50 or fewer, skip the following and go to section 3C.

Group number _____

3B EMPLOYEE COUNT *(continued)*

If your total number of employees noted above is more than 50, please provide the total number of **full-time-equivalent employees** on the line below. For information on calculating the number of full-time-equivalent employees (FTE), refer to **healthcare.gov** or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 50 full-time-equivalent employees on at least 50% of 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: _____

Employee only coverage[1] ☐ Yes ☐ No

[1] If you have 50 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 COVERAGE

Do you wish to select Domestic Partner Coverage? ☐ Yes ☐ No

5 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

6 ERISA STATUS

Is your company subject to ERISA?[2] ☐ Yes ☐ No If you do not select an answer, we will 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 are not. If you are unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

7 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)**

8 RENEWAL DELIVERY PREFERENCE

We will deliver your Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)/Kaiser Permanente Insurance Company (KPIC) renewal(s) online in a PDF file at **account.kp.org** unless you indicate below that you would like your renewal(s) mailed to you.

☐ I want to receive my renewal(s) by mail.

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)** ☐ Email ☐ Mail

Group number _____

10 BILLING CONTACT INFORMATION/THIRD-PARTY ADMINISTRATOR (TPA) 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 is not authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed.
The **Third-Party Administrator (TPA)** contact is an external person, company, or broker that is contracted for the purpose of administering the group's billing and enrollment or solely administering your COBRA benefits. This person will have access to group information, but is not authorized to sign the group agreement or to make contractual changes to your account.

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

TPA company name

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)** ☐ Email ☐ Mail			

11 MEDICAL PLANS

The [HMO], [HMO Plus], [Deductible HMO (DHMO)], [Deductible HMO Plus (DHMO Plus)], [Added Choice POS], and [Flexible Choice (3TPOS) (Option 1 HMO)] benefits are underwritten by KFHP-MAS. The [Flexible Choice (3TPOS) (Option 2 POS & Option 3 Out-of-Network)] benefits are underwritten by KPIC. *The employer retains sole discretion whether to open and contribute, and how much to contribute, to a Health Savings Account (HSA) account for employees who enroll in certain plans. **Groups may select up to 4 medical plans.**

Dental benefits are underwritten by KFHP-MAS and administered by Dominion National. Groups may select 1 dental plan. Groups that intend to request the composite premium rating calculation may not select a dental enhancement.

VA SMALL GROUP PLANS

	Signature	Select		Signature	Select
KP VA Platinum 0/15/Vision	☐	☐	KP VA Silver 3000/30/HSA/Vision*	☐	☐
KP VA Platinum 500/20/Vision	☐	☐	KP VA Silver 4000/0%/HSA/Vision*	☐	☐
KP VA Gold 0/20/Vision	☐	☐	KP VA Bronze 7000/40%/Vision	☐	☐
KP VA Gold 0/20/POS/Vision	☐	☐	KP VA Bronze 7000/50/Vision	☐	☐
KP VA Gold 500/20/Vision	☐	☐	KP VA Bronze 6150/30/20%/HSA/Vision	☐	☐
KP VA Gold 1000/20/Vision	☐	☐	KP VA Bronze 6850/0%/HSA/Vision	☐	☐
KP VA Gold 1000/20/POS/Vision	☐	☐	KP VA Platinum HMO Plus 0/15/Vision	☐	Not Applicable
KP VA Gold 1500/20/Vision	☐	☐	KP VA Gold HMO Plus 0/20/Vision	☐	Not Applicable
KP VA Gold 1400/0%/HSA/Vision*	☐	☐	KP VA Gold DHMO Plus 1500/20/Vision	☐	Not Applicable
KP VA Silver 2000/40/Vision	☐	☐	KP VA Gold 500/20/3TPOS/Vision	☐	Not Applicable
KP VA Silver 2000/30/HSA/Vision*		☐	KP VA Gold 1000/30/3TPOS/Vision	☐	Not Applicable
KP VA Silver 2750/30/Vision		☐	KP VA Silver DHMO Plus 2000/40/Vision	☐	Not Applicable
KP VA Silver 2750/30/POS/Vision		☐	KP VA Bronze DHMO Plus 7000/50/Vision	☐	Not Applicable

Group number _____

11 MEDICAL PLANS *(continued)*

DENTAL ENHANCEMENTS (OPTIONAL)					
HMO adult dental rider - age 19 or older	☐	☐	POS 2nd Level adult dental rider – age 19 or older	☐	☐
POS 1 adult dental rider – age 19 or older	☐	☐	POS 3 adult dental rider – age 19 or older	☐	☐

12 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. The agent or the broker do not have the power on behalf of KFHP-MAS/KPIC to make or modify any application for coverage, to make any promise or representation, or to waive any of the companies' (KFHP-MAS/KPIC) rights or requirements.

13 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 KFHP-MAS 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.

Agent name	License number

Phone	Fax	Cellphone
( ) –	( ) –	( ) –

Email

Firm name	EIN/TIN	Kaiser Permanente broker firm ID

Street address	City	State	ZIP

Agent/broker signature	Date
X	

General agency

Your broker is/may be paid commissions and other financial incentives by Kaiser Foundation Health Plan of the Mid-AtlanticStates, Inc.

Group number _____

14 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP-MAS and KPIC, I agree that:

- The group coverage applied for in this application will not become effective until:
  a) This application is approved by KFHP-MAS/KPIC;
  b) An advance payment equal to an estimated one-month premium is received by KFHP-MAS/KPIC; and
  c) That if the cost of the coverage is to be contributory, the required percentage of the eligible employees shall have agreed to make the required contribution.
  d) 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 KFHP-MAS and KPIC for new employees.
- In submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The applicant is not the agent or representative of KFHP-MAS/KPIC for any purpose of this application or any group agreement that is issued pursuant to this application, except enrollment. The eligibility data provided by my company to KFHP-MAS 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. All full-time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date. 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. I agree to be financially liable to KFHP-MAS and KPIC for any errors and/or omissions.
- My company will abide by the contract provisions.

I certify that my company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I attest that the minimum participation requirement of eligible employees are covered by group coverage. (If the plan is noncontributory, then 100% of the eligible employees must be enrolled. If the plan is contributory, then [70%] of the net-eligible employees must be enrolled; net-eligible employees equals the total eligible employees less employees with other health coverage).

I understand, that unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are "Eligible Employees" of the applicant, or a subsidiary or affiliate listed within this application. "Eligible Employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include "part-time employees." "Employee" as the meaning given such term under section 3(6) or the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1002(6)).

I agree to offer enrollment in the KFHP-MAS/KPIC products to all individuals entitled to coverage on conditions no less favorable than those for any other health care plan available through the group.

I agree that a bona fide employer/employee relationship exists with respect to each subscriber to be enrolled in the KFHP-MAS/KPIC products.

I acknowledge that this attestation may be subject to verification and agree to provide KFHP-MAS with any information necessary to do so.

I agree to abide by the Kaiser Permanente deductible funding policy, which does not permit directly funding or reimbursing employees for any deductibles, coinsurance, or copays, in accordance with the federal tax laws for HSA plans or PPO medical plans.

I attest that my company is not participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage. I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **account.kp.org**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

☐ **We are applying for coverage during the period that begins on November 15 and extends through December 15, thus not subject to a minimum participation or employer contribution requirement.**

I agree to hold an open enrollment period 30 days prior to the group's contract renewal date, during which all individuals entitled to coverage are offered a choice of enrollment in the KFHP-MAS/KPIC products.

Group number _____

14 AGREEMENT AND SIGNATURE *(continued)*

I understand and agree, as the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers; a) will become part of any group agreement which may ultimately be issued by KFHP-MAS/KPIC; and b) are made to induce KFHP-MAS/KPIC to issue the group coverage as applied for. I have the authority to make the statements and representations contained in this application and to execute this application on behalf of the group.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

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

For KFHP-MAS office use only

☐ Approved
☐ Declined
☐ Closed Out
☐ Withdrawn

Authorized by: _____

Date Finalized: _____

Approved Effective Date: ____ / ____ / ____

Comments: