KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

2019 New and Renewing Large Group Application

Company's legal name	DBA(s)
Group number	

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). If we have not heard from you or your producer, we will begin to implement your renewal, with no changes other than those required, 30 days before the effective date.

☐ Information change ____ If renewing coverage with changes, complete all other applicable sections. If renewing coverage with no changes, check the "no change" box in other sections.

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 new 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) _____
☐ Added Choice® plan (HSA-qualified) _____
☐ Added Choice® plan (point of service) _____
Do you have employees who both live and work outside our service area?* ☐ Yes ☐ No
☐ PPO Plus® plan (HSA-qualified)* _____
☐ PPO Plus® plan (point of service)* _____
☐ Dental plan _____

**If you have employees who both live and work outside our service area, they will be enrolled in a PPO Plus plan.*

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 _____
☐ Hearing aid rider _____
☐ Pediatric vision hardware rider _____
☐ Adult vision hardware rider _____
☐ Dental orthodontics rider _____
☐ Dental implant rider _____
☐ Infertility treatment rider _____

Accumulate out-of-pocket expenses on ☐ calendar year ☐ plan year

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

Section II: Premium and eligibility*

Plan premium rates
(Please write the plan name and premium rates for each premium tier and each plan below.)

Plan name					
Employee					
Employee/Spouse					
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): _____

*Custom Employee Enrollment Forms must be reviewed by Kaiser Foundation Health Plan of the Northwest and also filed with the state for use in Washington.

How many hours per week must employees work to be eligible for health care coverage? _____ 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. 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. Termination processing ☐ Last day of the month following or coinciding with eligibility end date ☐ Date eligibility ends	Overage dependent limiting age (cannot be under 26) To _____ years Overage student limiting age (cannot be under 26) To _____ years

This plan will cover ☐ Employees and dependents ☐ Employees only ☐ Surviving dependents ☐ Special eligibility _____ (requires approval)	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.	
Number of eligible employees _____	Number of ineligible employees _____	Total number of employees _____

Section III: Employer information ☐ No change

Type of business	NAIC code (required)	Tax identification number

Please check all that apply:

☐ Publicly traded corporation
☐ Privately held corporation
☐ State government
☐ Local government
☐ Church group
☐ Corporation
☐ Partnership
☐ Limited partnership
☐ Proprietor
☐ Not-for-profit
☐ Other

In business since

Do you have workers who are independent contractors or who do seasonal work? ☐ Yes ☐ No

Group plan sponsor

☐ Association ☐ Employer ☐ Labor organization
☐ Trustees or fund established by one or more employers or labor organizations

Is the business a branch office? ☐ Yes ☐ No	Is the business a subsidiary? ☐ Yes ☐ No

Group administrator/primary contact

Name

Address	City	State	ZIP

Email	Telephone	Fax

Billing name Billing address	City	State	ZIP

Email	Telephone	Fax

Corporate headquarters address (if different from above)	City	State	ZIP

Has your firm ever contracted with KFHPNW? ☐ Yes ☐ 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?
☐ Yes ☐ No

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
☐ 90 days ☐ 120 days ☐ Other (how many days?) _____ (requires approval)

Do any of your employees have Medicare? ☐ Yes ☐ No	If retirees are 65 or older, how is your retirement drug plan set up? ☐ Medicare Part D ☐ Retiree Drug Subsidy (RDS) ☐ Other
Retiree eligibility age ☐ No retirement plan offered ☐ Younger than 65 ☐ 65 or older	

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 percent of the employee premium for the lowest cost medical plan or 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

If yes, was prior underwriting approval obtained? ☐ 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 may include imprisonment, fines, and denial of insurance benefits. For Oregon state employers: you acknowledge by your signature that the information you have supplied on this form is true and correct. You may be guilty of insurance fraud if you 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.

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