KAISER PERMANENTE®

Small Business Group

2017 Master application for small groups (1–50 employees)

For coverage effective on or after Jan. 1, 2017

1. COVERAGE EFFECTIVE DATE

Group name _____

First of (month) _____ Group number(s) _____

2. APPLICATION CHECKLIST

NEW SALES

Application package must be received by the **20th of the month prior to the effective date** and include the following:

- ☐ **Completed and signed master application.**
- ☐ A current copy of employer's **Washington state business license**.
- ☐ **Completed enrollment forms** for each employee electing coverage OR **completed electronic census.**
- ☐ Enrollment forms for former employees who are eligible for COBRA.
- ☐ **For groups of 1–3 subscribers,** waiver form for each eligible employee declining coverage.
- ☐ **For groups of 1–3 subscribers,** show proof of being a business by submitting the appropriate tax documentation forms:

Corporation	1120 (First 4 pages)
Subchapter S Corp	1120S (First 4 pages)
Partnership	1065 (First 4 pages)
Nonprofit	990
Religious organization	Tax forms not required

RENEWALS

Renewal application must be received by the **10th of the month prior to the effective date.**

- ☐ **Review current benefits:**
  Medical _____
  Dental _____
- ☐ **Review 2017 plan choices and rate sheets.** You'll find information on available plans in the ***Compare your plan options*** brochure.
- ☐ **Complete all sections of this application, sign, and return** your completed form.

PLEASE NOTE: Under federal law, the term "group health plan" excludes plans that do not have employees and in which the only participant is a sole proprietor. 42 USCA §300gg-91(a); 29 CFR 2510.3-3(b) and (c). To be eligible for a small group plan, a group must have at least one common law employee.

3. REQUIRED COMPANY INFORMATION

Company name_____

Doing business as _____

Business address _____

City _____ State_____ ZIP _____ County _____

Phone _____ Fax _____Email _____

Type of business _____

In business since _____ Federal tax ID # _____ SIC # _____

Is this business a branch office? ☐ Yes ☐ No Or subsidiary? ☐ Yes ☐ No

In which city and state is your company headquartered? City _____ State _____

Has your firm ever been covered in the past by a plan offered by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc.?

☐ Yes ☐ No If yes, under what name? _____

Date last covered _____

Are you replacing existing group coverage? ☐ Yes ☐ No If yes, which carrier provided that coverage?

_____

4. REQUIRED CONTACT INFORMATION

Main contact name _____ Title _____

Company name_____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Billing contact (if different from above)

Name _____ Title _____

Company name_____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

5. REQUIRED ENROLLMENT INFORMATION

1. A small group is a business with 1–50 employees, as defined under applicable state and federal law. **Note:** To be eligible for a small group plan a group must have at least one common law employee. How many total employees, part-time and full-time combined, does your company have? Please include out-of-state and worldwide employees for all parent, subsidiary, and sibling companies in this total. _____
2. Did you ever employ 20 or more employees (part-time and full-time combined) for 20 or more calendar weeks in either the current or previous calendar year? ☐ Yes ☐ No
3. How many hours per week must employees work to be eligible for benefits? _____
4. How many employees meet the above requirement? _____
5. Of these employees, how many are enrolling? _____

   How many are waiving coverage? _____
6. Does your company have any terminated employees on COBRA benefits now? ☐ Yes ☐ No

   Employers with 20 or more full-time equivalent employees at least 50 percent of the year in the past calendar year are required by federal regulations to offer COBRA benefits to terminated employees. If you have any questions regarding COBRA applicability or eligibility, please seek the advice of independent legal counsel.
7. Employees will be eligible for benefits upon **(select one)**:
   - ☐ Date of hire
   - ☐ First of the month following date of hire
   - ☐ First of the month following ☐ 30 days ☐ 60 days
   - ☐ 90 days from date of hire
   - ☐ Other—No longer than 90 days from date that employee is otherwise eligible to enroll. Any orientation period required for an employee to be eligible to enroll may not exceed one calendar month (please specify). _____

     _____
8. Rehire policy:

   The company will waive the waiting period if employee is rehired **(select one)**:
   - ☐ Within 30 days of termination
   - ☐ Within 60 days of termination
   - ☐ Within 90 days of termination
   - ☐ Other: _____
9. Employee transfers from part-time to full-time **(select one)**:
   - ☐ Probationary period begins upon date employee transfers to full-time
   - ☐ Coverage begins on the 1st of the month following transfer to full-time
10. Does your company include non–state-registered domestic partners of employees as eligible dependents? **(Select one)**

    Note: State-registered domestic partners will be treated as spouses as required by Washington state law.

    ☐ Yes ☐ No

Premium contribution

The employer agrees to make the following contribution toward the employee and dependent coverage:

Employers must contribute a minimum of 50 percent of the employee premium to qualify for group coverage. Contribution applies to the base plan if eligible and offering more than one plan.

Employee $ or % _____ **Dependents $ or %** _____
(Minimum 50%) (None required)

6. RATING STRUCTURE

Select one: ☐ Age-banded rates (or "list bill," adults 21 and over are charged based on their age at plan effective date)

☐ Composite rates (comprised of two rates: one for all enrollees aged 21 and over that is determined by their combined average age-banded rate, and another that matches the age-banded rate for those 0–20)

7. SELECT BENEFITS

Select one of the health plans listed below.

OR

Groups with 10 or more employees may offer 1 plan or 2 plans from any combination of Core and Access plans. If offering 2 plans, groups with 10–24 employees must have at least 3 employees enrolled in each plan. Groups with 25 or more employees must have at least 5 employees enrolled in each plan.

Kaiser Foundation Health Plan of Washington Core provider network	**Kaiser Foundation Health Plan of Washington Options, Inc.** Access PPO provider network
☐ Bronze HSA ☐ Silver HSA ☐ Silver ☐ VisitsPlus Silver ☐ VisitsPlus Silver–EO‡ ☐ Gold ☐ VisitsPlus Gold HD* ☐ VisitsPlus Gold ☐ VisitsPlus Gold–EO‡ ☐ VisitsPlus Platinum	☐ Access PPO Bronze HSA ☐ Access PPO Silver HSA ☐ Access PPO VisitsPlus Silver ☐ Access PPO VisitsPlus Silver–EO‡ ☐ Access PPO VisitsPlus Gold ☐ Access PPO VisitsPlus Platinum

* HD—High deductible

‡ EO—Employee-only contract

Dental plan (must select one)

Please select one of the optional adult/family dental plans for your employees and their dependents OR choose the mandated pediatric-only dental coverage. Dependents include spouse/domestic partners and dependent children up to 26 years of age.

☐ Small Group Standard adult/family dental plan ($1,500 annual maximum)

☐ Small Group Basic adult/family dental plan ($1,000 annual maximum)

☐ Pediatric-only dental plan (This is required and must be added if no adult/family dental plan is chosen)
The Affordable Care Act mandates pediatric dental coverage for anyone under age 19 enrolled in the medical plan.

Note: Dental premiums for employees or applicable dependent enrollees under age 19 will be assessed and billed separately from the medical premiums.

Coverage provided by Delta Dental of Washington, 9706 Fourth Ave. N.E., Seattle, WA 98115-2157.

8. ACKNOWLEDGEMENTS AND CERTIFICATION

Authorized representative certification

I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. will have the right to cancel the contract to the extent allowable under applicable federal and state law. Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. reserve the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Full legal name _____ Title _____

Authorized representative's signature _____Date _____

Full legal name _____ Title _____

Authorized representative's signature _____Date _____

9. APPOINTMENT OF PRODUCER OF RECORD

Please complete this section if you have a Producer of Record representing your company.

I hereby appoint _____(Producer)

with _____ (Agency),

as a Producer of Record, effective _____, for purposes of arranging and servicing health care coverage with Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. for the firm's employees and dependents.

This appointment rescinds all previous appointments and continues in effect until termination by either party in writing. Producer may make requests concerning rates, benefits, eligibility requirements, and other matters relating to our company's coverage. The firm understands that commissions due to the Producer for services provided pursuant to the appointment are governed by an agreement between the Producer and the health plan.

If you are a Producer who completed this application on behalf of a client, please indicate by signing here.

Producer signature _____ Phone number_____

Name of Producer (please print)_____ Fax number _____

Address _____ Email _____

SS or tax ID number _____License number _____

10. SEND THE MATERIALS TO THE SALES OFFICE NEAREST YOU

Western Washington

Kaiser Foundation Health Plan of Washington
Small Business Group
320 Westlake Ave. N., Suite 100
Seattle, WA 98109-5233
206-448-4140 or 1-800-542-6312
Fax: 206-877-0654
Email: smallbusinessgroup@kp.org

Eastern Washington

Kaiser Foundation Health Plan of Washington
Small Business Group
5615 W. Sunset Highway
Spokane, WA 99224-9454
509-241-7471 or 1-800-497-2210
Fax: 509-459-1080
Email: smallbusinessgroup@kp.org

kp.org/wa/sbg

1-800-542-6312

KAISER PERMANENTE®

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Kaiser Permanente Civil Rights Coordinator.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Kaiser Permanente Civil Rights Coordinator, Kaiser Foundation Health Plan of Washington Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@kp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ បេយ័តន៖** បើសិនអ្កនិយាខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំអេអក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.