



KAISER PERMANENTE®

You've just taken the first step toward providing you and your employees with an outstanding health care benefit package from one of the nation's most respected health care organizations. Our commitment to excellence has made us one of the top-ranked health plans in the country, which means you and your employees will soon receive the quality care you deserve.

What Kaiser Permanente needs to implement group coverage:

- Completed Group Master Application
- Employee/Subscriber Applications For Each Covered Employee
- Last two quarters of DE-6 or legal Partnership Agreement.
- Groups enrolling Husband & Wife Only, provide Sole Proprietorship form.
- Your estimated first month's premium check payable to: Kaiser Permanente.

Mail to:

Attn:

Questions? Call _____ from 8 a.m. to 6 p.m., five days a week. A Small Business Sales Representative will be happy to help you!

Enrollment provisions

ENROLLMENT ELIGIBILITY AND COST CONTRIBUTIONS

The following summary provides some important details about enrollment eligibility, employer contributions, and payroll deductions to cover the cost of coverage. Please see your Group Agreement for more information about eligibility, participation, and contribution requirements.

COMPANY ELIGIBILITY FOR COVERAGE

Your company qualifies for our small group coverage if you have at least two but no more than 50 full-time employees worldwide (working at least 30 hours per week).

CALIFORNIA ENROLLMENT GUIDELINES

Your group must enroll a minimum of one employee in our small group coverage, with at least 70 percent of eligible employees covered by any group health plan (that is, through their employer or their spouse's employer, etc.).

EMPLOYEE AND FAMILY DEPENDENT ELIGIBILITY

Employees and their family dependents (spouse/domestic partner, unmarried children to age 19, and students to age 24) are eligible for coverage if the employee lives or works within our ZIP code Service Areas listed on the next page.

ANNUAL OPEN ENROLLMENT

Once a year, employees must be given the opportunity to change plans or add dependents not previously enrolled. Employees and/or dependents who do not enroll when first eligible must wait until the annual open enrollment period to enroll, unless enrollment is due to new dependents or loss of other coverage.

EMPLOYER'S CONTRIBUTION AND PAYROLL DEDUCTION

Your minimum cost contribution must be the greater dollar amount of the following scenarios: (a) 50 percent of the employee-only rate for the less-than 30 age-band, or (b) the required equal dollar amount contribution to an alternate plan your company may offer.

Any part of the cost not paid by your company must be collected from the employees through payroll deduction.

FULL-MONTH COVERAGE

Kaiser Permanente membership begins on the first day of the month following the waiting period that you specify for new hires and continues through the end of the termination month.

This application for Kaiser Foundation Health Plan, Inc. (Health Plan) benefits is intended for the business(es) below (attach additional sheets if necessary).

■ **Effective date** _____

Please select and circle one plan

Deductible Plans	\$30/\$1,000 Plan	\$20/\$1,000 Plan	\$10/\$1,000 Plan		
Copayment Plans	\$50 Plan	\$30 Plan	\$20 Plan	\$15 Plan	\$5 Plan
Paired Option	Paired Option				
POS Plans*	\$25 POS Plan	\$35 POS Plan	POS Plan with Infertility		

*Jointly offered by Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company (KPIC).

- Check here to select the *optional* **Delta Dental** coverage, underwritten by KPIC. **Select and circle one plan below.**
- Check here to select the *optional* **Chiropractic** benefit.

Plan C	Plan D	Plan E	Plan E w ortho (requires at least 25 subscribers)
Plan D PPO 1500	Plan E PPO 1000	Plan E PPO 1500	

(If your group selects a dental plan or chiropractic benefit, each subscriber and dependent enrolling in the medical plan must also enroll in the dental plan or chiropractic benefit.)

Business name _____

Address (in California) _____

City _____ State _____ ZIP _____

Phone _____ Fax number _____ E-mail (By giving Kaiser Permanente your e-mail address, you agree to receive e-mail from us.) _____

Type of business or SIC/NAICS code (optional) _____ In business since _____

- Check here if you had previous group insurance through Kaiser Permanente.
(Please provide your previous Kaiser Permanente Group Number _____.)

- If your group has 20 or more employees, select one of the following choices for administering COBRA: Group-administered billing Kaiser Permanente-administered billing

Principal Owners/Corporate Officers

1. Name _____ Title _____ Social Security number/EIN _____

2. Name _____ Title _____ Social Security number/EIN _____

- Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under Health Plan.
- How long must a new hire be employed before being offered health care benefits? **Benefits are effective the first of the month following the waiting period.** (check one) Date of hire 30 days 60 days 90 days 180 days 365 days
- Mr. Mrs. Ms.

■ Billing statements to be mailed to (person/title) Address City State ZIP _____

■ Contract to be mailed to (person/title) Address City State ZIP _____

Check here if this person is authorized to make changes to your contract.

- Interested Party (An Interested Party is authorized to access information about your account.)

Please complete, sign, and date below. I authorize the following individual to act as Broker of Record for Kaiser Foundation Health Plan, Inc.

Broker name _____ Firm name _____

Broker address _____

City _____ State _____ ZIP _____

() ()

Phone _____ Fax _____

ACal L&D Lic. # _____ Exp. date _____ Kaiser Permanente Broker ID # _____

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc., I agree that my company will contribute at least 50 percent of the employee-only rate for the < 30 age-band for each subscriber, that our prepaid monthly dues will be submitted by the 30th of each month prior to the month of coverage, that my company will use enrollment application forms that are provided or approved by Health Plan, and that my company will abide by the contract provisions.

Binding Arbitration Agreement: Disputes between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to the *Group Agreement*, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to the *Group Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under the *Group Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid.

If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice. Note: Binding arbitration does not apply to disputes with Kaiser Permanente Insurance Company (KPIC) or disputes with out-of-network providers.

X
Employer Signature _____ Title _____ Date _____

(If not listed on DE 6)

To establish the relationship between proprietors, partners, and/or corporate officers to the below-referenced company, please complete and return this form.

I attest that, although my name does not appear on the DE 6 wage report of the below-named company, the following conditions are true:

1. I am a sole proprietor, partner of a partnership, or corporate officer.
2. I actively work at the below-named company.
3. I draw wages, dividends, or other distributions from the below-named company on at least a monthly basis and am not eligible for group health coverage from any other employment.
4. I work on a permanent, full-time basis for the below-named company for at least 20 hours per week.
5. I satisfied the designated waiting period before coverage becomes effective.
6. I must provide, upon request from Kaiser Permanente, a copy of my company's fictitious name statement, DBA, legal partnership agreement and Schedule K, Articles of Incorporation, Schedule C, current business license, or current professional license.

I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc., with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage from Kaiser Foundation Health Plan, Inc., for the below-named company.

X

Proprietor, Partner, or
Corporate Officer's Signature

Print Proprietor, Partner, or Corporate Officer's Name

Title

Date

Company Name

X

Proprietor, Partner, or
Corporate Officer's Signature

Print Proprietor, Partner, or Corporate Officer's Name

Title

Date

Company Name

Enrollment Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name	Date of hire	
Group number	Enrollment unit	Effective date of enrollment or coverage

NEW ENROLLMENT *Check one:*

<input type="checkbox"/> New purchaser	<input type="checkbox"/> Open enrollment (complete sections A, B, C, D)
<input type="checkbox"/> New hire (complete sections A, B, C, D)	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Loss of other coverage (complete sections A, B, C, D)	Date of event _____

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

<input type="checkbox"/> Add dependents (complete sections A, B, D)	<input type="checkbox"/> Delete dependents (complete sections A, B, D)
*Reason: _____ (see Change Reason Table)	Event date: _____
<input type="checkbox"/> Name change (complete sections A, B, D) From: _____ To: _____	
<input type="checkbox"/> Address (complete section A) _____	
<input type="checkbox"/> Telephone (complete section A) _____	

A. EMPLOYEE INFORMATION

Name (Last, First, MI)	Former last name (if any)			
Home address	Apt. no.	City	State	ZIP
Home phone	Work phone	Medical record number (if known)		
<input type="checkbox"/> M <input type="checkbox"/> F Gender	E-mail	Social Security number		
Date of birth	Preferred spoken or written language (optional)	Ethnicity (optional)		

B. FAMILY INFORMATION

 For additional dependents, attach a separate sheet and please put the employee's name at the top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Spouse/Domestic partner name:	Date of birth MM/DD/YY	Medical record number
Former last name (if any):		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Dependent name:	Date of birth MM/DD/YY	Medical record number
Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Dependent name:	Date of birth MM/DD/YY	Medical record number
Relationship:		

Do any of your dependents above live at another address? Yes No If yes, complete the following:

Name(s) (Last, First, MI):	Address:
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C. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? Yes No

Name	Insurance carrier name	Policy number/Effective date	Phone number
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D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by *binding arbitration* under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the *Evidence of Coverage*.

Employee/Applicant signature	Date	Employer signature (optional)	Date
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*Additional documentation may be required.

Enrollment Form

General instructions:

1. Please print legibly in black ink.
2. To be enrolled, you must live or work within one of the ZIP codes listed in the "Enrollment" section of this booklet.
3. The employer must complete the first section labeled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A through C. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including completed employer section), the subscriber should make a copy for his/her records to use with the Temporary Membership ID, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment reason information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates as they affect the Health Plan dues.

If making a change, the subscriber must always complete this section, even when making minor changes to the account. This ensures our information is current. Please mark the box if your address is new.

Section A: The subscriber must complete this section.

Section B: The subscriber must indicate the requested change they are making to their account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding their rules for overage dependent students. A completed Student Certification form may be required.

Sections C, D: The subscriber must complete these sections.

Change Reason Table

Add dependent reason

Event date

Acquired student status*

Date student status was obtained

Family adoption*

Date of adoption

Loss of coverage

Date coverage was lost

New spouse (marriage)*

Date of marriage

Moved into service area

Move date

Newborn addition

Date of birth

Open enrollment

Open enrollment effective date

Delete dependent reason

Event date

Loss of student status

Date of status change

Divorce

Date of divorce

Member deceased*

Date of death

Delete dependent(s)

Dependent termination date

Open enrollment

Open enrollment effective date

*Additional documentation may be required.