



KAISER PERMANENTE®

Kaiser Foundation Health Plan of Ohio (KFHPOH)

1001 Lakeside Avenue, Suite 1200 Cleveland, OH 44114

Kaiser Permanente Insurance Company (KPIC)

One Kaiser Plaza Oakland, CA 94612

Employer Group Application For Large and Small Employer Groups

APPLICATION is hereby made for group health coverage based upon the following statements and representations:

Section 1: EMPLOYER'S INFORMATION			
Purchaser's Legal Business Name		Application Date	
Street Address	City	State	Zip Code
Billing Address (if different from above)	City	State	Zip Code
Executive Contact Person	Title	Phone	Fax
Billing Contact Person	Title	Phone	Fax
Nature of Business		Business Email Address	
Years in Business	Federal Tax ID Number	Primary SIC code	
Union Local Name & Number		Requested Effective Date	
Check type of company: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation - S <input type="checkbox"/> Corporation - C <input type="checkbox"/> Other (specify): _____			
<input type="checkbox"/> COBRA <input type="checkbox"/> St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees COBRA continuation. If your group had fewer than 20 employees, you must provide State continuation.		
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact their legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.		
In the past 36 months, has your company filed for protection or operated under federal/state bankruptcy laws (Chapter 11 or 7)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past 36 months, has any creditor filed or threatened to file a petition requesting the company be placed involuntarily into bankruptcy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Section 2: EMPLOYEE ELIGIBILITY			
Group Size 2-50	Within Our Service Area	Outside Our Service Area	Total
Total # of employees working 25 hours or more per week			
Total # of employees working Less than 25 hours per week			
Group Size 51+			
Total number of employees eligible for group health coverage			
Number of hours per week required to be eligible for health coverage _____ <i>For small group, active employees must work 25 hours or more per week.</i>			
For groups of 51+ are early retirees eligible for benefits?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
For groups of 51+ are Medicare retirees eligible for coverage?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Note: Medicare Primary employees/retirees may not be eligible for the POS or PPO Plan products. Small Group (2-50) retirees are not eligible.</i>			
NEWLY HIRED EMPLOYEES ARE ELIGIBLE FOR COVERAGE: (Check one box)			
<input type="checkbox"/> First of the Month Following date of hire <input type="checkbox"/> First of the Month Following 30 days <input type="checkbox"/> First of the Month Following 60 days <input type="checkbox"/> First of the Month Following 90 days (Not available for 2-50) <input type="checkbox"/> Other _____			
The Newly Hired options for the "Other" category will be as follows: Premium will be billed for the entire month for coverage effective on or between the 1st and 15th of the month. Premium will be billed the following month for coverage effective the 16th of the month or after.			
Waive probationary period on initial enrollment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
COVERAGE ENDS: (Check one box)			
<input type="checkbox"/> End of the month following date of termination. Premium billed for the entire month. <input type="checkbox"/> Date of termination. No premium billed for terminations effective on or between 1st and 15th of the month. Premium billed for the entire month for terminations on the 16th of the month or after.			

Section 3: BENEFIT SELECTION**Medical Plan(s):**

HMO Plan #(s) _____ Out of Area PPO Plan #(s) _____ HDHP HMO Plan #(s) _____

Added Choice POS Plan #(s) _____ Other: _____

Optional Benefits: (Must check dental coverage for small group HMO Plans 1, 2 and 4)

Dental Coverage Vision Hardware Coverage Other (specify): _____

In the event you have Medicare primary beneficiaries, please indicate which of the following applies:

Medicare Part D coverage (default) _____ Retiree Drug Subsidy _____

The HMO plan and the Tier 1, HMO level of the Added Choice POS plan are underwritten by Kaiser Foundation Health Plan of Ohio (KFHPOH). Kaiser Permanente Insurance Company (KPIC) underwrites the Tier 2 and 3 levels of the Added Choice POS Plan and the Out of Area PPO plan. Dental coverage is underwritten by Delta Dental Plan of Ohio. Vision Hardware coverage administered and underwritten by VSP® VisionCare.

Section 4: OTHER HEALTH CARE COVERAGE INFORMATION

Annual Open Enrollment is held during the month(s) of: _____

For effective coverage on: _____

Has your business ever contracted with Kaiser Foundation Health Plan of Ohio?

If yes, under what name and former group number: _____

Yes No

Are you applying for these health benefits to replace current or prior coverage provided by another group health carrier?

If yes, please specify: _____

Yes No

Carrier's/Plan Name	Group/Policy Number	Effective Date	Renewal Date

Will you be offering another health care program or insurance in addition to Kaiser Permanente? If yes, please specify: (If more than one other carrier is offered, please attach additional carrier information. Note minimum participation guidelines in your group agreement.) (Not available in Small Group)

Yes No

Carrier's/Plan Name	Group/Policy Number	Effective Date	Renewal Date

Has an insurance carrier terminated your coverage in the past five years?

If yes, please specify: _____

Yes No

Carrier's/Plan Name	Reason for Termination

Please specify dollar amount or percentage your Employer contributes towards health care premiums.

Employer must contribute at least 50% of the single rate of the plan selected or the same as contributed to any alternative plan, whichever is greater.

Employee \$ _____ or _____ %

Employee and Spouse \$ _____ or _____ %

Employee and Child \$ _____ or _____ %

Employee and Children \$ _____ or _____ %

Employee and Family \$ _____ or _____ %

Retirees (not eligible in small group) \$ _____ or _____ %

Other (specify): _____ \$ _____ or _____ %

Section 5: GROUP ELIGIBILITY REQUIREMENTS

- 1.) For small group, employer must have a minimum of two (2) eligible employees to enroll. The minimum enrollment requirement is 75% of eligibles after valid waivers.
- 2.) Eligible employees must reside in one of the counties in the service area: Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Stark, Summit, Wayne, or one of our 10 contiguous counties **(Medicare products are not available in Wayne and Stark counties.)**
- 3.) Employer must offer Kaiser Permanente to all eligible employees.

Section 6: EMPLOYER AGREEMENT

The employer agrees to the following:

- 1.) To offer enrollment in the KFHPOH HMO plan, the joint KFHPOH-KPIC POS product and the KPIC OOA product to all persons entitled to coverage on conditions no less favorable than those for any other health care plan available through the Group.
- 2.) A bona fide employer/employee relationship exists with enrollees. This requirement does not apply to eligible Taft-Hartley trusts and partnerships.
- 3.) For groups of 51+, no more than 10 percent of expected combined enrollment in our health plan may be COBRA and/or non-Medicare retirees unless approved by KFHPOH/KPIC prior to the group's effective date.
- 4.) As required by state law, employer group has workers' compensation coverage for its employees.
- 5.) That it will hold an open enrollment period at least once a year, during which all persons entitled to coverage are offered a choice of enrollment in KFHPOH/KPIC and any health care plan available through the Group.
- 6.) That any material misstatement or omission of information made on this form, or any other document submitted in connection with this application, will be considered a misrepresentation and may be the basis of later rescission of coverage issued on the basis of submitted information.
- 7.) That the Group coverage applied for in this application will not become effective until:
 - a. This application is approved by KFHPOH and/or KPIC.
 - b. An advance payment equal to an estimated one month's premium is received by KFHPOH and/or KPIC.
 - c. That if the cost of coverage is to be contributory, the required percentage of the eligible employees have agreed to make that required contribution.
- 8.) That any agent or the broker does not have the power on behalf of KFHPOH and/or KPIC to make or modify any application of coverage, to make any promise or representation, or to waive any of the companies' (KFHPOH/KPIC) rights or requirements.

Section 7: GROUP ACKNOWLEDGEMENT

I have read the Group Eligibility Requirements and the Employer Agreement and agree to comply. Furthermore, I understand and agree, on behalf of the employer, as plan sponsor, that the statements in this application and answers to the Employer Group Risk Questionnaire, if applicable, 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 KFHPOH; b) will become part of any policy or policies which may ultimately be issued by KPIC; and c) are made to induce KFHPOH and/or KPIC to issue the group coverage, as applied for.

Signed at _____ on _____
City State Month Day Year

By _____
(Full Name in print of officer or person authorized to purchase plan)

Signature _____ Title _____

OHIO FRAUD WARNING: Any person who, with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Section 8: BROKER/AGENT OF RECORD

Broker/Consultant Name			
Agency/Firm Name			Federal Tax ID/SSN
Street Address			City
State	Zip Code	Phone	Fax

I hereby appoint the individual named above as broker/agent of record effective _____. This appointment rescinds all previous appointments and continues in effect until termination by either party in writing. I authorize Kaiser Foundation Health Plan of Ohio to furnish Agent with all information the Agent may request concerning rates, benefits, eligibility requirements and other matters relating to Health Plan coverage. I understand that commissions due to the Agent for services provided pursuant to this appointment are governed by an agreement between the Agent and Health Plan.

Company Officer Name (print): _____ Title: _____

Company Officer Signature: _____ Date: _____

For Health Plan Use Only:

Marketing Representative	Marketing Representative Code	Effective Date	Renewal Date
Commission <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Standard <input type="checkbox"/> Other		Open Enrollment Month	Open Enrollment Effective Date
Group #			

Bill Groups / Sub-Groups Needed:

BETS Request ID # of Sold Quotes:

--	--	--	--	--

Below:
 Attach sold rate sheets or complete sold rates.

Special Instructions / Comments:
