KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, CA 94612

Kaiser Permanente Level Funded Application and Banking Arrangements

Administrative Services Only (Colorado Service Area)

Please complete fully, sign and return to your Kaiser Permanente representative. Any missing information may cause a delay.

I. Application

Requested effective date: ______________________________

1. ABOUT YOUR BUSINESS

____
Full Legal Business Name (write on line above)

____
Doing Business As (DBA)

Physical Address ____________ City ____________ State ______ ZIP code ______

Mailing Address if Different Than Physical Address ____________ City ____________ State ______ ZIP code ______

Nature of Business (please be specific) ____________ Phone Number ____________

# of Years in Business ______ Federal Tax ID Number (EIN/TIN) ______ Standard Industry Code (SIC) ______ NAICS Code (6 digits) ______

Renewal Date ______ Open Enrollment Start Date ______ Open Enrollment End Date ______

Type of Business

☐ Corporation ☐ Labor-Union ☐ Partnership ☐ Limited liability company (LLC)

☐ Sole Proprietorship ☐ Other (fill in type) ______________________________

Are you subject to ERISA? ☐ Yes ☐ No

If No, select reason for exemption: ☐ Government Entity ☐ Church Plan
☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Other: ______________

Please provide names and locations (street address, city, state, postal code) for any affiliates and subsidiaries covered within the plan:

____

____

____

2. ENROLLMENT INFORMATION

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 one employer and must apply as one employer. If your company is affiliated with another company, is your company eligible to file a combined tax return?

☐ Yes ☐ No

Please provide the total number of eligible employees:* ______________________________

Are all eligible employees associated with the same TIN/EIN? ☐ Yes ☐ No

If no, please specify employees names and corresponding TIN/EIN ______________________________

Normal work week an employee is required to work to be eligible for your Plan: ________ hours per week

Do you have any seasonal, temporary, independent contractors (1099), and leased employees? ☐ Yes ☐ No

Number of enrolled employees: __________________ Number of employees waiving coverage: ________________

Number of full-time employees: __________________ Number of part-time employees: ________________________

Are you subject to the requirements of COBRA? ☐ Yes ☐ No

Total number of COBRA participants if applicable: ___________
Please attach COBRA coverage and end dates.

Describe any applicable employee classifications:______________________________

New hire waiting period/When coverage begins. Please select one:

☐ 1st of month following date of hire

☐ 1st of month following date of hire or on date of hire if it is the first of the month

☐ 1st of month following ________ days or ________ months after date of hire (not to exceed 90 days)

☐ Other: __________________

Total number of employees in benefit waiting period and not yet eligible: _________

Rehire/When coverage begins. Please describe: ______________________________

Plan participant termination date: ☐ End of month

Will you offer dependent coverage?** ☐ Yes ☐ No Will you offer coverage to domestic partners? ☐ Yes ☐ No

---

* Please provide the total number of full-time and full-time-equivalent employees. For information on calculating the number of full-time and full-time-equivalent employees (FTE), please consult your legal counsel. To qualify for Kaiser Permanente Level Funded program, your company must have at least five (5) full-time and full-time-equivalent employees.

** Please contact your advisor for information regarding your Employer Shared Responsibility as a plan sponsor under the Affordable Care Act (ACA). See section 4980(H)(C)(2) of the Internal Revenue Code.

3. OTHER MEDICAL OFFERINGS

Does your company or affiliated company(ies) have, or ever had, group coverage issued by Kaiser Permanente?

☐ Yes ☐ No

If yes, please provide the group ID and company name.

Group ID ______________________

Company Name ______________________

Does your company currently have active health coverage? ☐ Yes ☐ No
☐ Fully Insured ☐ Self-Funding

If Yes, Name of Carrier ______________________

Renewal Date ______________________

Carrier Phone Number ______________________

Please list other coverage in the last three years not disclosed above:

Name of Prior Carrier ______________________

Prior Coverage Start Date ______________________

Prior Coverage End Date ______________________

Name of Prior Carrier ______________________

Prior Coverage Start Date ______________________

Prior Coverage End Date ______________________

4. WORKERS' COMPENSATION INSURANCE

All employees must be covered by workers' compensation insurance, unless not required to be covered by law.

Do you have workers' compensation insurance? ☐ Yes ☐ No

If you claim an exemption from any state requirement to offer workers' compensation insurance, please state below the basis for such exemption.

I attest that the following information is correct.

☐ Yes, my company has workers' compensation insurance
☐ Pending

If yes or pending, name of carrier:______________________ and Policy #: ______________________

If exempt from providing workers' compensation insurance, list reason: ______________________

5. SURPLUS OPTION

Select surplus option: ☐ 50% ☐ 67%

6. PLANS / BENEFITS SELECTED

You can select up to a maximum of six (6) plans with no more than two (2) out-of-area (OOA) PPOs or point of service (POS) plans, regardless of your group's size. Employers with less than 20 employees are encouraged to pick no more than five (5) plans. For more information on the plans and network offerings listed below, contact your sales representative or broker/producer.

EPO	KPLF EPO 0/10/1500 KPLF EPO 0/20/3000	KPLF EPO 0/30/4000
Deductible EPO	KPLF DEPO 250/10%/3000 KPLF DEPO 500/10%/3000 KPLF DEPO 500/20%/3000 KPLF DEPO 750/20%/3000 KPLF DEPO 1000/10%/3000 KPLF DEPO 1000/20%/4000 KPLF DEPO 1500/10%/4000 KPLF DEPO 1500/20%/4000 KPLF DEPO 2000/0%/4500 KPLF DEPO 2000/20%/4500 KPLF DEPO 2000/30%/4500 KPLF DEPO 2500/0%/4500 KPLF DEPO 2500/20%/4500 KPLF DEPO 2500/30%/6000 KPLF DEPO 3000/0%/6000 KPLF DEPO 3000/20%/6000	KPLF DEPO 3000/30%/6000 KPLF DEPO 3500/0%/6500 KPLF DEPO 3500/20%/6500 KPLF DEPO 3500/30%/6500 KPLF DEPO 4000/0%/6500 KPLF DEPO 4000/20%/8000 KPLF DEPO 4000/30%/8000 KPLF DEPO 4000/40%/8000 KPLF DEPO 4000/50%/8000 KPLF DEPO 5000/0%/8000 KPLF DEPO 5000/20%/9000 KPLF DEPO 5000/30%/9000 KPLF DEPO 5000/40%/9000 KPLF DEPO 5000/50%/9000 KPLF DEPO 6000/40%/9000 KPLF DEPO 6000/50%/9000
Kaiser Permanente Everyday Care EPO	KPLF EC 4000/0%/4000 KPLF EC 5000/0%/5000	KPLF EC 7000/0%/7000 KPLF EC 9000/0%/9000
HDHP EPO	KPLF HDHP 1700/20%/3500 KPLF HDHP 2500/20%/5000 KPLF HDHP 3000/0%/3000 KPLF HDHP 3500/20%/6000	KPLF HDHP 4000/0%/4000 KPLF HDHP 5000/30%/7000 KPLF HDHP 6000/50%/8000
POS (In-service area)	KPLF POS 500/10%/3000 KPLF POS 1500/20%/4000	KPLF POS 3000/30%/5000 KPLF POS 5000/30%/7000
POS HDHP (In-service area)	KPLF POS HDHP 3500/30%/5000	KPLF POS HDHP 5000/30%/6500
OOA PPO (Out-of-service area)	KPLF PPO 2000/25%/7500 KPLF PPO 3500/35%/9000	KPLF PPO 5000/40%/9000 KPLF PPO 7000/40%/9000
OOA PPO HDHP (Out-of-service area)	KPLF PPO HDHP 5500/40%/7000	

6. PLANS / BENEFITS SELECTED (*continued*)

The following summarizes the benefit plans that you will be offering to your eligible full-time/part-time employees:

	Plan Name	Customization?	Plus*	Describe customization
Traditional Plans				
Plan 1		☐ Yes ☐ No	☐ Yes ☐ No	
Plan 2		☐ Yes ☐ No	☐ Yes ☐ No	
Plan 3		☐ Yes ☐ No	☐ Yes ☐ No	
Plan 4		☐ Yes ☐ No	☐ Yes ☐ No	
POS and OOA PPO (if applicable				
Plan 5				
Plan 6				

* HDHP Plans are not eligible for Plus

Reimbursement of member cost sharing	Do you self-fund any portion of the deductibles, copayments, or cost-shares for your employees? ☐ Yes ☐ No If yes, what portion is funded per employee? ______________________________ If yes, total amount on an annual basis? __________________________________
Employer contributions	Choose your medical contribution for each month – only **one** choice is allowed. Traditional contribution option 1: Employer will contribute _________% per employee (50-100%) _________% per dependent (optional 0-100%) Fixed dollar contribution option 2: Employer will contribute (at least $100 in $5 increments): _______________ Percentage of plan contribution option 3: Employer will contribute (50-100%): _________% to the following plan_________________________________

6. PLANS / BENEFITS SELECTED (*continued*)

OPTIONAL SERVICES		
Do you want to add KP Health Payment Account?	☐ Yes	☐ No
If yes, which KP Health Payment Account(s) are you choosing:	**Health savings account (HSA)**	☐ HSA with a card
	Health reimbursement arrangement (HRA)	☐ HRA 213(d) with a card ☐ HRA Health plan-only with automatic reimbursement ☐ HRA Deductible-only with automatic reimbursement
	Flexible spending account (FSA)	☐ Medical FSA ☐ Dependent care FSA ☐ Limited-purpose FSA (must be paired with an HSA)
LEGAL AND ADMINISTRATIVE INFORMATION		
Please provide the following information for the plan. This information will be reflected in your Benefit Booklet(s).	Plan Name (as Provided to the Department of Labor on the Form 5500):	
	ID Number (ERISA Plan Number):	
	Plan Administrator (Name & Address):	
	Please provide a contact name and physical address for legal process documents to be delivered.	

7. MEDICARE

Prior calendar year average total number of employees ____________________

Is your Plan primary?* ☐ Yes (20 employees or more) ☐ No (less than 20 employees)

* Under federal law, if your company had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Plan is primary and Medicare is secondary. This statement does not set forth all rules governing Medicare status. You should contact your legal counsel for information regarding other rules that may impact your company's Medicare status.

8. PLAN CONTACTS

Plan Administrator (see Plan Administrator designation in section 12 below)

Name (write on line above)

Title

Administrator Mailing Address (if different than Physical Address)

Administrator Phone

Administrator Email Address

Authorized Bank Account Signer

Name

Title

Mailing Address (if different than Physical Address)

Phone

Email Address

Billing

Name

Title

Phone

Email Address

Designate additional COBRA and Reporting contacts when handled by someone other than the above contacts.

COBRA (if applicable)

Name

Title

Business Name (complete if TPA is handling COBRA Administration)

Phone

Email Address

Will the TPA be administering Federal COBRA? ☐ Yes ☐ No

Reporting

Name

Title

Phone

Email Address

9. PLAN PHI RECIPIENT(S)

#1 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

#2 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

#3 Contact Name

Mailing Address (if different from main address)

Phone

Email Address

NOTE: Only designated recipients are authorized to access reports from Kaiser Permanente containing PHI, access to the website, and/or receive information when calling customer service on behalf of the employee and their dependent(s). Multiple designees are acceptable. If you have additional PHI recipients, please list the additional PHI recipients on a separate piece of paper and attach to the application.

10. NOTICE CONTACTS

The Plan Sponsor must designate one or more persons to receive and be legally responsible for any notices provided under the ASO Agreement. The Plan Sponsor acknowledges and agrees that receipt of official notices by the Notice Contact shall constitute notice to the Plan Sponsor.

Notice Contact 1 (required)

Notice Contact Name/Title or Notice Contact Department

Notice Contact Email

Notice Contact Address

City

State

ZIP code

Notice Contact 2 (optional)

Notice Contact Name/Title or Notice Contact Department

Notice Contact Email

Notice Contact Address

City

State

ZIP code

11. BROKER OF RECORD / BROKER COMPENSATION / GENERAL AGENCY

AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE: To be completed by your Kaiser Permanente appointed agent/broker after completion of this Level Funded Application. With your authorization, your broker will have the same access to your group's information as the Plan Sponsor; however, a broker cannot sign section 13 of this Level Funded Application.

If you are a broker who has not registered as a firm or agent with Kaiser Permanente, or if any information has changed since you first registered, please contact your Kaiser Permanente representative.

Notice to agent or broker: you must select Yes or No. I assisted the applicant in submitting this Level Funded Application. To the best of my knowledge, the information on this Level Funded Application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate or misleading information, and the applicant understands these risks. ☐ Yes ☐ No

Licensed Broker Representative Name ______________________ License Number ______________________

Firm Name ______________________ KP Broker Firm ID ______________________

Broker Phone Number ______________________ Broker Email Address ______________________

Broker Mailing Address ______________________

Did you agree to a non-standard broker commissions amount? If yes, what amount was agreed upon? ______________

Agent/Broker Signature ______________________ General Agency ______________________ Today's Date ______________________

12. IMPORTANT INFORMATION

1. Kaiser Permanente Insurance Company (KPIC) provides administrative services only and underwrites stop loss insurance for the Kaiser Permanente Level Funded program.
2. KPIC will not agree to provide any administrative services (including the preparation of a Benefit Booklet) or issue Stop Loss insurance until it has completed its review of the information in this document and executed an agreement with the Plan Sponsor. The Plan Sponsor may be subject to an underwriting validation at any time to verify the accuracy of the information provided to KPIC.
3. HIPAA Compliance. Upon receipt of this Level Funded Application Form, KPIC will review your application. By signing below with your typed electronic signature, you agree on behalf of the Plan Sponsor that: (a) the group health plan and its agents will comply with applicable HIPAA Privacy Regulation (including the minimum necessary requirements), applicable state confidentiality requirements, and the terms of the KPIC Business Associate Agreement between the parties; and (b) the Plan Sponsor and its agents will keep any KPIC proprietary information confidential and will not further use or disclose this information without advance written notice to KPIC. By signing below with your typed electronic signature, the Plan Sponsor further agrees that KPIC will only provide the minimum amount of PHI necessary for a permitted business purpose, as determined by KPIC in its sole discretion. The Plan Sponsor may also receive Summary Health Information, and may disclose enrollment and disenrollment information to KPIC.

   You represent that as a HIPAA Covered Entity permitted to receive PHI, the group health plan has reasonable procedures in place for handling PHI as required by HIPAA and applicable state confidentiality law with respect to the use and disclosure of PHI, including the following, and KPIC shall be entitled to rely on such representation:

   - Designate a privacy official.
   - Designate a contact person or office that is responsible for receiving complaints and who is able to provide further information about matters covered by the group health plan's privacy notice.
   - Train all members of its workforce on confidentiality policies and procedures.
   - Document that the training has been provided.
   - Adopt appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.

12. IMPORTANT INFORMATION *(continued)*

- Provide a process for individuals to make complaints concerning the group health plan's confidentiality policies and procedures or its compliance with such policies and procedures.
- Document all complaints received, and their disposition, if any.
- Adopt and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the group health plan.
- Document the sanctions that are applied, if any.
- Mitigate, to the extent practicable, any harmful effect that is known to the group health plan of a use or disclosure of PHI in violation of its policies and procedures.
- Implement policies and procedures with respect to PHI that are designed to comply with the standards, implementation specifications or other requirements of the HIPAA Privacy Regulations.

By authorizing KPIC to disclose PHI to your employees or agents of the group health plan, or to any Business Associate, Vendor or other Third Party, you represent and warrant that you have made a determination that such parties may receive, use, and disclose PHI as permitted or required by HIPAA and applicable state and federal law; you acknowledge that such PHI may be further disclosed by the recipient; and you agree to indemnify, and at KPIC's request, hold KPIC and its affiliates and their respective directors, officers, and employees ("KPIC Indemnitees") harmless from and against any claim, cause of action, liability, judgment, arbitration award, damage, cost or expense, including reasonable attorneys' fees and costs, arising out of or in connection with any non-permitted use or disclosure of PHI provided at your request to any employees or agents of the group health plan, or to the group health plan's Business Associate, Vendor, or other Third Party.

13. AUTHORIZED PLAN SPONSOR SIGNATORY

The Plan Administrator is responsible for signing the Administrative Services Only (ASO) Agreement, including amendments thereto; providing renewal information; and is authorized to make eligibility and enrollment determinations.

As the Group representative, I have the authority to make the statements and representations contained in this Level Funded Application Form and to execute this application on behalf of KPIC's RFQ Health Questionnaire (or your broker's equivalent questionnaire) (if attached) are true and complete to the best of my knowledge and belief. I understand and agree that such statements and representations: (a) will become part of any agreement issued by KPIC; and, (b) are made to induce KPIC to furnish the administrative services requested.

Group Authorized Representative (please print)	Signature of Group Authorized Representative
Title (please print)	Today's Date

II. Banking Arrangements

Kaiser Permanente Corporate
Treasury Cash Management
One Kaiser Plaza, Floor 25B
Oakland, CA 94612

Legal Business Name: ______________________________

Method of Payment

You [Plan Sponsor] agree to utilize The Consolidated Account* in the name of Kaiser Permanente Insurance Company (KPIC)("Account"). The Account will be utilized as the depository and/or funding account for your Level Funded Plan when KPIC administers your plan.

If you require any further information or authority with respect to this Account, please contact Nancy Tran, Kaiser Corporate Treasury at Nancy.T.Tran@kp.org.

Statement of Understanding

1. You understand and agree to the following on behalf of your business:
   a. You will establish a Plan Sponsor Account* and KPIC is authorized to debit your Plan Sponsor Account monthly, even if an overdraft is created by such debit, in any amounts equal to the Total Amount Due* stated on the Monthly Level Funded Billing Invoice. You are responsible for all amounts drawn by KPIC on your behalf and for any overdrafts, including fees thereon created by such payments. The amount debited shall be deposited in the Consolidated Account.
   b. Through debits of the Plan Sponsor Account, you will fund the Consolidated Account monthly in amounts equal to the Total Amount Due stated on the Monthly Level Funded Invoice*. You have the obligation to maintain funds in the Plan Sponsor Account in order for the ACH drawdown to occur on the first day of the month or the next business day as applicable.
   c. KPIC has established the Consolidated Account with Citibank, and Citibank is authorized to debit the Plan Sponsor Account via ACH drawdown monthly.
   d. You will ensure sufficient funds are in your Plan Sponsor Account to cover the monthly debit of the Plan Sponsor Account. If the necessary funds are not on deposit in the Plans Sponsor Account, your Administrative Services Only (ASO) Agreement with KPIC may be subject to termination under the terms in the ASO Agreement. You understand your business may be subject to liability, including additional costs incurred by KPIC, resulting from your failure to adequately fund the Plan Sponsor Account as required by the ASO Agreement.
   e. You will promptly notify your Kaiser Permanente Account Manager and email ES.LF@kp.org of any change to your Plan Sponsor Account. If a change occurs, it is your responsibility to provide current information in a timely manner.
   f. You will notify your Kaiser Permanente Account Manager and email ES.LF@kp.org promptly in writing of any change in the Plan Sponsor's administrative services instructions to KPIC set forth in this letter. In addition, Citibank is hereby authorized to follow any instructions by KPIC with respect to the Plan Sponsor Account and changes thereto.

*Capitalized terms are defined in the ASO Agreement.

Plan Sponsor Account Information for Electronic Funds Transfer

Bank Name: ______________________________

Bank ABA Number: ______________________________

Bank Account Number: ______________________________

Account Name: ______________________________

I have authority to enter into this Statement of Understanding as, or on behalf of, the Plan Sponsor. This authorization to establish a Plan Sponsor Account to be debited as described herein is to remain in full force and effect unless my Kaiser Permanente Account Manager has received written notice of the Plan Sponsor's intent to terminate this authorization. I understand that I must give at least 10 business days written advance notice to my Kaiser Permanente Account Manager in order to terminate or change this authorization.

Authorized Bank Account Owner or Designee: ______________________________

Signature of Authorized Bank Account Owner or Designee: ______________________________

Title: ______________________________ Today's Date: ______________________________

SAMPLE LETTER TO BE PROVIDED TO YOUR BANK FOR DEBIT AUTHORIZATION TO YOUR BANK ACCOUNT.

[Insert current date]

Bank Contact
Bank Name
Address
City and State, ZIP

RE: ACH Debit Authorization Instructions *[insert Plan Sponsor bank account #]*

Dear [Bank Contact],

Please use this letter as authorization from *[Plan Sponsor-insert your name here]* to allow the initiation of monthly (or as needed) ACH debits by Citibank, NA. The ACH debits will be drawn on behalf of Kaiser Permanente Insurance Company (KPIC).

The following information will be included in each of the ACH debit transactions:

Account Name:	Kaiser Permanente Insurance Company
Bank/Company:	Citibank, Delaware
Account #:	54052201
ABA #:	Account ABA # 031100209
Citibank:	Company ACH ID 9900000006
Bank Contact:	Erin Bogart, (302) 324-6625
Address:	One Penn's Way, New Castle, Delaware, 19720

If you have any questions please do not hesitate to contact *[Plan Sponsor-insert your name here]* at (xxx) xxx-xxxx, ext #.

1558527402 December 2024