

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

Requested effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**1 ABOUT BUSINESS**

Legal business name (as stated on your local business license, quarterly wage and tax report, corporate or partnership documents)		Doing business as (DBA)	
Physical street address (no P.O. boxes)	City	State	ZIP
County	Phone (     )                    -		
Type of business	Corporation	Sole proprietorship	Partnership
			Limited liability company (LLC)
			Other:
In business since (mm/dd/yyyy) / /	Federal tax ID (EIN) number	NAICS code (6 digits — visit <a href="http://naics.com/search">naics.com/search</a> )	Business website

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage if you don't have workers' compensation, unless you're exempt. I attest that the following information is correct.  
 Yes, my company has workers' compensation.      Pending

If **Yes** or **Pending**, name of carrier: \_\_\_\_\_ Policy # \_\_\_\_\_  
 (indicate *unknown* or *pending* as applicable)

Exempt from providing workers' compensation for the following reason: \_\_\_\_\_

**2 OTHER MEDICAL COVERAGE**

Does your company or affiliated company(ies) have or has it ever had group coverage directly through Kaiser Permanente? If Yes, please provide the group number and company name.

Yes    No    Group #: \_\_\_\_\_ Company name: \_\_\_\_\_

Does your company currently have active group health coverage?

Yes    No    Name of carrier: \_\_\_\_\_ Renewal month: \_\_\_\_\_

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

Yes    No    Name of carrier: \_\_\_\_\_ Renewal month: \_\_\_\_\_ **Number of employees enrolled:** \_\_\_\_\_

**3A EMPLOYER ELIGIBILITY**

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 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return?      Yes      No      If Yes, please provide below:

Company name		Affiliate	Subsidiary
Address	City	State	ZIP
Federal tax ID number	Phone (     )                    -		

Business name (please print): \_\_\_\_\_

**3B EMPLOYEE COUNT**Please provide the total number of employees nationwide (**full-time and part-time**).

Total \_\_\_\_\_

Please provide the total number of **full-time and full-time-equivalent employees** during the prior calendar year on the line below.To qualify for small group coverage, your company must have at least 1 but no more than 50 full-time and full-time-equivalent employees during the prior calendar year. For information on calculating the number of full-time and full-time-equivalent employees, refer to [HealthCare.gov](https://www.healthcare.gov) or your legal counsel.

Total \_\_\_\_\_

**3C ELIGIBLE AND ENROLLING EMPLOYEES**Please provide the total number of **eligible employees**. Total \_\_\_\_\_Please provide the total number of **enrolling employees**. Total \_\_\_\_\_

Total number of employees eligible for Medicare coverage: \_\_\_\_\_

Hours per week employees must work to be eligible for coverage: \_\_\_\_\_

Employee-only plan (no dependents can enroll)<sup>1</sup>    Yes    No<sup>1</sup>If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980(H)(C)(2) of the Internal Revenue Code.**4 CONTINUATION COVERAGE**

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA?    Yes    No

Are you submitting COBRA applications?    Yes    No

**5A ERISA STATUS**Is your company subject to ERISA?<sup>2</sup>    Yes    No    If you do not select an answer, we'll record your status as Yes.<sup>2</sup>ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally aren't. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal adviser before responding.**5B MEDICARE SECONDARY PAYOR STATUS**Are you subject to TEFRA?<sup>3</sup>    Yes    No<sup>3</sup>If your company employed 20 or more full-time and/or part-time employees for each working date for 20 or more calendar weeks in the current calendar year or preceding calendar year, your group is subject to this federal law.

Business name (please print): \_\_\_\_\_

**6 EMPLOYER PREMIUM CONTRIBUTION**

Your contribution to coverage can be a percentage or a fixed dollar amount. **Your minimum contribution must be at least 50% of the “employee only” monthly premium for the lowest-priced Kaiser Permanente medical and dental plan(s) offered by you, the employer (with the exception of voluntary dental).**

 Percentage of the premium is based on the following **(select 1 only)**:

Lowest plan offered      All plans offered      Specific plan offered: \_\_\_\_\_

 Employer medical contribution (% or \$): \_\_\_\_\_ per employee \_\_\_\_\_ per dependent premium **(optional)**

 Employer dental contribution (% or \$): \_\_\_\_\_ per employee \_\_\_\_\_ per dependent premium **(optional)**
**7A CONTRACT SIGNER INFORMATION**

This person is responsible for receiving and providing renewal information and is authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title	
Mailing address		City	State	ZIP
Office phone (       )       -	Ext.	Cell phone (       )       -		
Email	How should we correspond with this person? <b>(select 1 only)</b> <input type="checkbox"/> Email <input type="checkbox"/> Mail			

**7B BILLING CONTACT INFORMATION**

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information. Only 1 billing contact is allowed.

**Check here if same as contract signer.**

First name	MI	Last name		
Mailing address		City	State	ZIP
Office phone (       )       -	Ext.	Cell phone (       )       -		
Email	How should we correspond with this person? <b>(select 1 only)</b> <input type="checkbox"/> Email <input type="checkbox"/> Mail			



Business name (please print): \_\_\_\_\_

<b>Kaiser Permanente Plus™ Deductible Plans</b>	The following consumer-directed health plans are available with KP Plus deductible plans: HRA, FSA, stacked HRA/FSA.		
	KP OR Gold KP Plus 1000	KP OR Silver KP Plus 3000	KP OR Bronze KP Plus 7000
<b>Added Choice® Plans</b>	The following consumer-directed health plans are available with Added Choice plans: HRA, FSA, stacked HRA/FSA.		
	KP OR Platinum Added Choice 250	KP OR Gold Added Choice 1000	KP OR Silver Added Choice 4000
	KP OR Platinum Added Choice OOA 250 <sup>1</sup>	KP OR Gold Added Choice OOA 1000 <sup>1</sup>	KP OR Silver Added Choice OOA 4000 <sup>1</sup>
	KP OR Gold Added Choice 500	KP OR Silver Added Choice 3000	KP OR Bronze Added Choice 7000
	KP OR Gold Added Choice OOA 500 <sup>1</sup>	KP OR Silver Added Choice OOA 3000 <sup>1</sup>	KP OR Bronze Added Choice OOA 7000 <sup>1</sup>

<sup>1</sup>Added Choice OOA plans: If you have employees who both live and work outside our service area, we may be able to enroll them in an Added Choice out-of-area plan. Rates and approval subject to approval by underwriting. Group must meet underwriting requirements to purchase.

## 8C FAMILY DENTAL PLANS

### Family dental plan options

All KFHPNW Small Business Medical Plans, except for the Oregon Standard plans, have pediatric dental coverage included. If you want to offer orthodontia coverage for members 18 and younger, you must offer a KFHPNW Small Business Family Dental Plan with Ortho. For dependents to be covered, the subscriber must enroll.

<b>Traditional<sup>2</sup></b>	KP OR Family Traditional — \$1000 KP OR Family Traditional — \$1000/\$50 Ded KP OR Family Traditional — \$1000/\$100 Ded KP OR Family Traditional — \$1000/\$100 Ded + Ortho KP OR Family Traditional — \$1500 KP OR Family Traditional — \$1500/\$50 Ded KP OR Family Traditional — \$1500/\$100 Ded KP OR Family Traditional — \$1500/\$100 Ded + Ortho	KP OR Family Traditional — \$2000 KP OR Family Traditional — \$2000/\$50 Ded KP OR Family Traditional — \$2000/\$100 Ded KP OR Family Traditional — \$2000/\$100 Ded + Implants KP OR Family Traditional — \$2000/\$100 Ded + Ortho KP OR Family Traditional — \$2000/\$100 Ded + Ortho + Implants KP OR Family Traditional — \$2500/\$50 Ded KP OR Family Traditional — \$2500/\$100 Ded	KP OR Family Traditional — \$2500/\$100 Ded + Implants KP OR Family Traditional — \$2500/\$100 Ded + Ortho KP OR Family Traditional — \$2500/\$100 Ded + Ortho + Implants KP OR Family Traditional — \$3000/\$50 Ded KP OR Family Traditional — \$3000/\$100 Ded KP OR Family Traditional — \$3000/\$100 Ded + Implants KP OR Family Traditional — \$3000/\$100 Ded + Ortho KP OR Family Traditional — \$3000/\$100 Ded + Ortho + Implants
<b>Voluntary Traditional<sup>2</sup></b>	KP OR Family Traditional — \$1000/\$50 Ded — Voluntary	KP OR Family Traditional — \$1500/\$50 Ded — Voluntary	KP OR Family Traditional — \$2000/\$50 Ded — Voluntary
<b>Dental Choice (PPO)</b>	KP OR Family Choice — \$1000/\$50 Ded KP OR Family Choice — \$1000/\$100 Ded KP OR Family Choice — \$1000/\$100 Ded + Ortho KP OR Family Choice — \$1500/\$50 Ded KP OR Family Choice — \$1500/\$100 Ded KP OR Family Choice — \$1500/\$100 Ded + Ortho	KP OR Family Choice — \$2000/\$50 Ded KP OR Family Choice — \$2000/\$100 Ded KP OR Family Choice — \$2000/\$100 Ded + Implants KP OR Family Choice — \$2000/\$100 Ded + Ortho KP OR Family Choice — \$2000/\$100 Ded + Ortho + Implants KP OR Family Choice — \$2500/\$50 Ded	KP OR Family Choice — \$2500/\$100 Ded KP OR Family Choice — \$2500/\$100 Ded + Implants KP OR Family Choice — \$2500/\$100 Ded + Ortho KP OR Family Choice — \$2500/\$100 Ded + Ortho + Implants
<b>Voluntary Choice (PPO)</b>	KP OR Family Choice — \$1000/\$50 Ded — Voluntary	KP OR Family Choice — \$1500/\$50 Ded — Voluntary	KP OR Family Choice — \$2000/\$50 Ded — Voluntary

<sup>2</sup>Traditional Dental plans are not available to employers in the following ZIP codes: 97390, 97412, 97413, 97430, 97434, 97439, 97453, 97463, 97480, 97488, 97490, 97492, 97493. Employers may select a PPO/Choice plan.

Business name (please print): \_\_\_\_\_

**9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY**

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan of the Northwest (KFHPNW) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

**10 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE**

**To be completed by broker.** To the best of my knowledge and belief, employment and other information on this application is complete and accurate. I acknowledge that I represent and am acting on behalf of my client and not for, or as, an employee of KFHPNW. I have explained the benefits and limitations of coverage and advised my client not to terminate any existing coverage until receiving written notice that the coverage being applied for under the new program has been approved.

I understand that I have no right to bind this coverage or to alter terms of the insurance.

**Primary (authorized agent/broker)**

Agent/broker name	% split
Preferred phone ( ) –	Email
Firm name	Kaiser Permanente broker firm ID
Agent/broker signature <b>X</b>	Date

**Secondary (only if adding another firm; does not apply to a second agent/broker at the same firm)**

Agent/broker name	% split
Preferred phone ( ) –	Email
Firm name	Kaiser Permanente broker firm ID

Business name (please print): \_\_\_\_\_

## 11 AGREEMENT AND SIGNATURE

### DOMESTIC PARTNER COVERAGE

As required by state law, coverage for state-registered domestic partners is included in all small group plans. Please refer to the Oregon Revised Statute (ORS) for a current definition.

Employers may choose to provide coverage for non-state-registered domestic partners. A special election for the expanded offering is not required. Kaiser Permanente will process enrollments per the request of the group through our employee enrollment process; however, coverage should be provided uniformly to all similarly situated employees and their dependents.

### DETERMINING GROUP SIZE UNDER OREGON LAW

Oregon Administrative Rule (OAR) 836-053-0015 establishes the method for defining a small employer. This rule and its Exhibit provide specific details about how to count employees toward the small and large group size thresholds. Generally speaking, a small employer in Oregon is one that employed (on average, during the prior calendar year) 1–50 full-time employees, including full-time-equivalent employees. A prescribed calculation determines the number of full-time and full-time-equivalent employees. Companies with a common owner or that are otherwise related under certain rules of Section 414 of the Internal Revenue Code are generally combined and treated as a single group.

To be considered a small employer under Oregon law (OAR 836-053-0015), the employer must employ at least 1 common law employee **who is enrolled on the plan at the beginning of the plan year.**

For more information on how to count employees toward the 1–50 threshold, which employees to count, and how to identify controlled groups, refer to any of these sources:

- OAR 836-053-0015 (find this OAR at [secure.sos.state.or.us/oard/view.action?ruleNumber=836-053-0015](https://secure.sos.state.or.us/oard/view.action?ruleNumber=836-053-0015))
- Exhibit B to OAR 836-053-0015 (find this Exhibit at [dfp.oregon.gov/laws-rules/Documents/OAR/div53-0015\\_exB.pdf](https://dfp.oregon.gov/laws-rules/Documents/OAR/div53-0015_exB.pdf))
- IRS Publication, “Determining if an employer is an applicable large employer,” [irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer](https://irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer)
- You may also refer to [HealthCare.gov](https://www.healthcare.gov) or your legal counsel for information on calculating the number of full-time, full-time-equivalent, and eligible employees

An employee is considered a common law employee if the employer has the authority to direct and control the manner in which the services are performed by the individual. For more information, see Exhibit B to OAR 836-053-0015 (find this Exhibit at [dfp.oregon.gov/laws-rules/Documents/OAR/div53-0015\\_exB.pdf](https://dfp.oregon.gov/laws-rules/Documents/OAR/div53-0015_exB.pdf)).

### AGREEMENTS AND ATTESTATIONS

As a company principal/corporate officer, having authority to contract with KFHPNW, I agree that:

- Prepaid monthly premiums will be posted to Kaiser Permanente’s account by the due date on the Kaiser Permanente billing statement.
- My company will use employee enrollment application forms provided or approved by KFHPNW for new employees.
- The eligibility data provided by my company to Kaiser Permanente will include coverage effective dates for my company’s employees that correctly account for eligibility in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents won’t exceed the waiting period established by my company.
- My company will abide by the contract provisions.
- My company acknowledges that eligibility for domestic partners will comply with state law.

I have read, understood, and agreed to Kaiser Permanente’s Rating and Underwriting Assumptions Policy, which may be included with my rate quote or, if not included, is available online.

I attest that my company meets the definition of “small employer” as defined by applicable federal and state law. I have a minimum of 1 enrolling W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that the minimum participation requirements are met and 50% (valid waivers excluded) of eligible employees are covered by group coverage. For Voluntary Dental products, 5 members or 25% (whichever is greater) of eligible employees are covered.

Business name (please print): \_\_\_\_\_

I understand that if I have an authorized agent/broker/producer of record, then the agent/broker/producer and their support staff currently on file with Kaiser Permanente will have access to my group-specific information. They're able to service my organization and to act or change group information on my behalf. Access to my [business.kp.org](https://business.kp.org) group account will be granted to my agent/broker/producer who can delegate authority to their support staff. This information may include, but is not limited to, renewal notices, group agreements, rates, benefits, and protected health information (PHI).

I attest that if I have selected an Oregon Standard medical plan that I have also selected an Oregon family dental plan through KFHPNW or purchased pediatric dental coverage certified by Oregon Health Insurance Marketplace through another carrier.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at [kp.org/smallbusiness-sbc/nw](https://kp.org/smallbusiness-sbc/nw). I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. It may be 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.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente Plans <b>X</b>	Date