KAISER PERMANENTE®

Virginia Small Group

BROKER OF RECORD AUTHORIZATION
(NEW GROUP)

1 COMPANY INFORMATION

Company name	Federal tax ID (EIN) number

2 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE (TO BE COMPLETED BY AGENT/BROKER)

If you're a broker who hasn't registered as a firm or agent with Kaiser Permanente, contact Broker Support at **844-268-2943** or via email at **brokersupport-mas@kp.org**. Only fully appointed Kaiser Permanente agents/brokers are entitled to receive commissions in conjunction with the placement, installation, and/or servicing of our insurance contract/agreement.

Agent/Broker name	VA license #
Contact email	Contact phone (###-###-####)
Firm name	Kaiser Permanente broker firm ID

3 AGENT/BROKER AUTHORIZATION

By submitting and signing this request:

- I, for the undersigned group, hereby request to designate the agent/broker named above as our authorized agent/broker for Kaiser Foundation Health Plans.
- I authorize our designated agent/broker to complete, sign and submit forms on behalf of the group without the need for a signature from the group. I agree to be bound by transactions performed by the agent/broker on our behalf. This includes our agent/broker submitting an *Employer Application* form to contract with Kaiser Permanente for Small Group health care coverage.
- I authorize you to discuss and provide group-specific information to our designated agent/broker. This information includes, but is not limited to, our group plan agreement, rates, benefits, payment information and, to the extent permitted by applicable law, protected health information (PHI).

4 GENERAL AGENT INFORMATION (TO BE COMPLETED BY BROKER, IF APPLICABLE)

General agency name	General agency ID
Contact email	Contact phone (###-###-####)

5 GENERAL AGENT ACCESS (TO BE COMPLETED BY EMPLOYER, IF APPLICABLE)

Your agent/broker may work with a General Agent (GA) to service your organization, which is a different firm from your agent/broker. The same agent/broker access to your group-specific information and change permission will be granted to a designated GA unless you choose not to authorize access.

Do not check the box below if you consent.

☐ Check this box **ONLY** if you **DO NOT** authorize a GA to access your group-specific information, service your organization, change group information, or act on your behalf.

6 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP-MAS and KPIC, I agree that:

- The group coverage applied for in this application will not become effective until:
  a) This application is approved by KFHP-MAS/KPIC;
  b) An advance payment equal to an estimated one-month premium is received by KFHP-MAS/KPIC; and
  c) That if the cost of the coverage is to be contributory, the required percentage of the eligible employees shall have agreed to make the required contribution.
  d) 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 forms provided or approved by KFHP-MAS and KPIC for new employees.
- In submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The applicant is not the agent or representative of KFHP-MAS/KPIC for any purpose of this application or any group agreement that is issued pursuant to this application, except enrollment. The eligibility data provided by my company to KFHP-MAS 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. All full-time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date of KFHP-MAS's group agreement or KPIC's Group Policy. 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. I agree to be financially liable to KFHP-MAS and KPIC for any errors and/or omissions.
- My company will abide by the contract provisions. I certify that my company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage. I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I attest that the minimum participation requirement of eligible employees are covered by group coverage. (If the plan is noncontributory, then 100% of the eligible employees must be enrolled. If the plan is contributory, then [50%] of the net-eligible employees must be enrolled; net-eligible employees equals the total eligible employees less employees with other health coverage).
- I agree to furnish upon request to KFHP-MAS/KPIC all data necessary to verify group and employee eligibility including but not limited to data proving compliance with the underwriting requirements and the terms of the group agreement.
- I agree to provide KFHP-MAS/KPIC, proof of group and employee eligibility. KFHP-MAS/KPIC reserves the right to inspect the records of the group in order to verify the eligibility of employees and their dependents. Copies of the quarterly employee wage report and appropriate employer tax documentation may be required for any group at the discretion of KFHP-MAS/KPIC. I will maintain enrollment/waiver records for the purpose of regulatory state audits.

Domestic Partner Coverage

- Coverage for state-registered domestic partners is included in all small group plans. If children of the insured employee are covered, children of state-registered domestic partners are covered on the same basis.
- Employers may choose to provide coverage to domestic partners who are not registered with the state. Refer to the Employer Application you submitted: If "Yes" is selected in section 3D, and children of the insured employee are covered, children of non-state-registered domestic partners are covered on the same basis.

Kaiser Permanente is not advising on whether or not the law requires coverage for these individuals. Seek guidance from your counsel on dependent coverage obligations.

- In addition, the group must annually complete and return, in advance of the contract anniversary date, any and all documents requested by KFHP-MAS/KPIC in order to certify the group as a small employer.

I understand, that unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are "Eligible Employees" of the applicant, or a subsidiary or affiliate listed within this application. "Eligible Employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be broadened to include "parttime employees." "Employee" as the meaning given such term undersection 3(6) or the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1002(6)).

I agree to offer enrollment in the KFHP-MAS/KPIC products to all individuals entitled to coverage on conditions no less favorable than those for any other health care plan available through the group.

6 AGREEMENT AND SIGNATURE (CONTINUED)

I agree that a bona fide employer/employee relationship exists with respect to each subscriber to be enrolled in the KFHP-MAS/KPIC products.

I acknowledge that this attestation may be subject to verification and agree to provide KFHP-MAS with any information necessary to do so.

I agree to abide by the Kaiser Permanente deductible funding policy, which does not permit directly funding or reimbursing employees for any deductibles, coinsurance, or copays, in accordance with the federal tax laws for HSA plans or PPO medical plans.

I attest that my company is not participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage. I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **account.kp.org**.

I understand that if I have an authorized agent/broker of record, then the agent/broker 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 **account.kp.org** group account will be granted to my agent/broker 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 agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

We are applying for coverage during the period that begins on November 15 and extends through December 15, thus not subject to a minimum participation requirement or a contribution.

The agent or the broker does not have the power on behalf of KFHP-MAS/KPIC to make or modify any application for coverage, to make any promise or representation, or to waive any of the companies' (KFHP-MAS/KPIC) rights or requirements.

I agree to hold an open enrollment period 30 days prior to the group's contract renewal date, during which all individuals entitled to coverage are offered a choice of enrollment in the KFHP-MAS/KPIC products.

I understand and agree, as the employer, that the statements in this application 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 KFHP-MAS/ KPIC; and

b) are made to induce KFHP-MAS/KPIC to issue the group coverage as applied for.

I have the authority to make the statements and representations contained in this application and to execute this application on behalf of the group.

Virginia State Warning: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Authorized company signer (full name in print)	Title (print)
Signature	Date