KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)
[4000 Garden City Drive, 5th floor, Hyattsville, MD 20785]

Kaiser Permanente Insurance Company (KPIC)
[One Kaiser Plaza, Oakland, CA 94612]

Maryland Small Group
EMPLOYER APPLICATION

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) (if applicable)

Physical street address (no P.O. boxes)

City

State

Zip

County

Phone

Business website

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 naics.com/search)

All employees must be covered by workers' compensation, unless not required to be covered by law. You are not eligible to apply for coverage if you do not have workers' compensation, unless you are 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 the carrier: Renewal month:

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 _____

Note: If the total number of employees noted above is 50 or fewer, skip the following and go to section 3C.

If your total number of employees noted above is more than 50, please provide the total number of **full-time equivalent employees (FTEs)** on the line below. To qualify for small group coverage, your company must have at least 1 but no more than 50 FTEs on at least 50% of the previous calendar year. For information on calculating the number of FTEs, refer to **https://www.healthcare.gov/shop-calculators-fte** 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 _____

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

Are you offering dependent coverage?[1] Yes No

[1] 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.

3D DOMESTIC PARTNER COVERAGE

Do you wish to offer non-state registered Domestic Partner Coverage? Yes No

See Domestic Partner Coverage in the Agreement and Signature section for state registered and non-state registered domestic partner coverage details.

4 CONTINUATION OF 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?[2] Yes No If you do not select an answer, we will record your status as *Yes*.

[2] 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 are not. If you are unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

Business name (please print):

5B MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA?[1] Yes No

[1]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.

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage **or** a fixed dollar amount.

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

Lowest plan offered All plans offered Specific plan offered:

Employer contribution (50%-100%): % per employee % per dependent **(optional)**

Employer contribution (fixed $): $ per employee $ per dependent **(optional)**

7A CONTRACT SIGNER

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

7B BILLING CONTACT/THIRD-PARTY ADMINISTRATOR (TPA) CONTACT

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. The **Third Party Administrator (TPA)** contact is an external person, company, or broker that is contracted for the purpose of administering the group's billing and enrollment or solely administering your **Federal COBRA** benefits. This person will have access to group information.

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

TPA company name

First name | MI | Last name

Mailing address | City | State | Zip

Office phone | Ext. | Cellphone | Email

Business name (please print):

8A MEDICAL PLANS

Please select the rating methodology for your group: Age-banded rating Composite rating

The [HMO], [Kaiser Permanente Plus], [Deductible HMO], [Deductible Kaiser Permanente Plus], [Added Choice], [Qualified Health Savings Account (HSA) HDHP], [Flexible Choice (Option 1 HMO)], and [HSA-Qualified Flexible Choice (Option 1 HDHP)] benefits are underwritten by KFHP-MAS. The [Flexible Choice (Option 2 PPO & Option 3 Out-of-Network)] and [HSA-Qualified Flexible Choice (Option 2 PPO & Option 3 Out-of-Network)] benefits are underwritten by KPIC.

† The employer retains sole discretion whether to open and contribute, and how much to contribute, to a Health Savings Account (HSA) account for employees who enroll in certain plans. Groups may select up to 4 medical plans.

MARYLAND SMALL GROUP PLANS					
	Signature	Select		Signature	Select
[KP MD Platinum 0 Ded/Vision]			[KP MD Silver 1850 Ded/350 RxDed/Vision]		
[KP MD Platinum Plus 0 Ded/Vision]		N/A	[KP MD Silver Plus 1850 Ded/350 RxDed/Vision]		N/A
[KP MD Platinum 500 Ded/Vision]			[KP MD Silver 2500 Ded/500 RxDed/Vision]		
[KP MD Gold 0 Ded/Vision]			[KP MD Silver Added Choice 2500 Ded/500 RxDed]		N/A
[KP MD Gold Plus 0 Ded/Vision]		N/A	[KP MD Silver 4000 Ded/450 RxDed/Vision]		
[KP MD Gold 500 Ded/Vision]			[KP MD Silver Plus 4000 Ded/450 RxDed/Vision]		N/A
[KP MD Gold 1000 Ded/150 RxDed/Vision]			[KP MD Silver 5000 Ded/450 RxDed/Vision]		
[KP MD Gold Added Choice 1000 Ded/150 RxDed]		N/A	[KP MD Silver 2000 Ded/HSA/Vision†]		
[KP MD Gold 1500 Ded/200 RxDed/Vision]			[KP MD Silver 3000 Ded/HSA/Vision†]		
[KP MD Gold Plus 1500 Ded/200 RxDed/Vision]		N/A	[KP MD Silver 4000 Ded/HSA/Vision†]		
[KP MD Gold 3000 Ded/250 RxDed/Vision]			[KP MD Bronze 6500 Ded/Vision]		
[KP MD Gold 1700 Ded/HSA/Vision†]			[KP MD Bronze Plus 6500 Ded/Vision]		N/A
[KP MD Gold Flexible Choice 0 Ded/300 RxDed]		N/A	[KP MD Bronze 6150 Ded/HSA/Vision†]		
[KP MD Gold Flexible Choice 1000 Ded/200 RxDed]		N/A	[KP MD Bronze 7100 Ded/HSA/Vision†]		
[KP MD Gold Flexible Choice 1750 Ded/HSA/Vision†]		N/A			

Business name (please print): _____

8B DENTAL RIDER PLANS *(optional)*

Adult only (age 19 and older)		**Adult + family (adult plus child) cosmetic ortho**	
[SG Dental EPO]		[SG EPO + KP Family OrthoPlus]	
[SG Dental PPO Basic]		[SG Dental PPO Basic + KP Family OrthoPlus]	
[SG PPO]		[SG Dental PPO + KP Family OrthoPlus]	
[SG PPO High]		[SG Dental PPO High + KP Family OrthoPlus]	
[SG POS]		[SG Dental POS + KP Family OrthoPlus]	

Adult + child cosmetic ortho		**Child-only cosmetic ortho**	
[SG Dental EPO + KP Child OrthoPlus]		[KP OrthoPlus EPO (Child-only)]	
[SG Dental PPO Basic + KP Child OrthoPlus]		[KP OrthoPlus PPO (Child-only)]	
[SG Dental PPO + KP Child OrthoPlus]			
[SG Dental PPO High + KP Child OrthoPlus]			
[SG Dental POS + KP Child OrthoPlus]			

Small Group offering guidelines	
Multi-plan choice	Groups may offer multiple dental plans to their employees as long as the group meets health plan participation requirements.
Participation requirements	Applies at the group level, even when multiple adult plans are offered. Groups must meet [50%] participation.
Cosmetic ortho buy-up requirements	• A group must have a minimum of 5 enrolled members (excluding waivers), of any age regardless of the type of orthodontic coverage. • Cosmetic ortho may be selected to cover both adults and children (family ortho) or children only (child-only ortho). • If selected, the cosmetic ortho rider must be offered on all Kaiser Permanente Smile dental plan offerings for that group. • Only the first three children covered by cosmetic ortho are subject to rating.
PPO / POS reimbursement	All PPO and POS plans have out-of-network benefits that reimburse at the maximum allowed amount.
Flexible Choice / Added Choice health plans	Flexible Choice and Added Choice health plans include the KP Smile Kids SG Embedded Dental PPO plan and can only be paired with SG Adult Dental PPO or POS plans.

Please provide the total number of Enrolling Employees participating in Dental Option: _____

Dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. Groups that intend to request the composite premium rating calculation may not select a dental enhancement.

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, Inc. (KFHP-MAS), or Kaiser Permanente Insurance Company (KPIC) 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.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) and/or Kaiser Permanente Insurance Company (KPIC), collectively or individually referenced in this application as "Kaiser Permanente," "KFHP-MAS," or "KPIC."

10A 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 KFHP-MAS or KPIC. 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 | Email | % split

Firm name | National Producer Number (NPN) | Kaiser Permanente broker firm ID

Agent/broker signature | Date | General agency name

Secondary (only if adding another firm; doesn't apply to a second agent/broker at the same firm)

Agent/broker name | % split

Firm name | National Producer Number (NPN)

10B GENERAL AGENT ACCESS

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.

Business name (please print): _____

11 AGREEMENT AND SIGNATURE

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

- The effective date will be determined by KFHP-MAS/KPIC and will be the latest of:
  a) the date this application is given written approval by KFHP-MAS/KPIC; or
  b) any requested effective date not prior to the date the applicant signs this agreement and KFHP-MAS/KPIC approves the application; or
  c) the date KFHP-MAS/KPIC establishes for coverage to begin, in the event that this application is not accompanied by all information needed by KFHP-MAS/KPIC.
- Full first month's payment must be received and KFHP-MAS/KPIC must approve the application in writing for the plan to become effective.
- 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 issued pursuant to this application.
- The eligibility data provided by my company to KFHP-MAS/KPIC 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 will not exceed the waiting period established by my company. 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 will abide by the contract provisions. I agree to provide KFHP-MAS/KPIC, in writing, 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.

Domestic Partner Coverage

- Coverage for state-registered (civil union) 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. 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. Please 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 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 the group. In applying the minimum participation requirement to determine whether the [50%] of participation is met, KFHP-MAS/KPIC may not consider as eligible employees: those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Standard Plan; or employees under the age of 26 years who are covered under their parent's health benefit plan.

I understand that unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except dependents and those former members covered under a continuation of benefits, are "eligible employees" of the applicant, or of a subsidiary or affiliate listed within this application. "Eligible employee" means an employee who is offered coverage under a health benefit plan by a small employer. "Eligible employee," at the option of the small employer, may include: (1) only full-time employees; or (2) full-time employees and part-time employees.

Business name (please print):

11 AGREEMENT AND SIGNATURE *(continued)*

I agree to furnish KFHP-MAS/KPIC all data necessary for the efficient administration of the group coverage for the approved covered employees and dependents, if any.

It is understood and agreed that none of KFHP-MAS/KPIC's agents have the authority to:

- modify this application form;
- waive the answer to any question on this application form;
- bind KFHP-MAS/KPIC in any way by giving or receiving any data which is not written on this application form;
- alter or amend the Group plan or plans; or
- bind KFHP-MAS/KPIC by making any promise or representation not contained in this application form.

The employer agrees to the following:

- that this application is offered as an inducement for the group coverage applied for;
- that this application will form a part of any contract issued;
- that only the information in this application will bind KFHP-MAS/KPIC;
- that no waiver or charge will bind KFHP-MAS/KPIC unless signed by an executive officer of KFHP-MAS/KPIC;
- that group coverage will only be provided for persons eligible under the plans issued; and
- that employer must maintain enrollment/waiver records for the purpose of regulatory state audits.

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 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 understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **account.kp.org**.

I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

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.

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.

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. If you have any questions concerning the benefits and services that are to be provided by or excluded under the coverage that is the subject of this application, please contact a membership services representative before signing this application.

Maryland State Warning: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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