

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 <input type="checkbox"/> Corporation <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company (LLC) <input type="checkbox"/> Other:			
In business since (mm/dd/yyyy) / /	Federal tax ID (EIN) number	NAICS code (6 digits — visit naics.com/search)	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		<input type="checkbox"/> Affiliate <input type="checkbox"/> Subsidiary	
Address	City	State	ZIP
Federal tax ID number	Phone () -		

Business name (please print): _____

3B EMPLOYEE COUNTPlease 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 EMPLOYEESPlease 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)¹ ☐ Yes ☐ No

¹If 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?² ☐ Yes ☐ No If you do not select an answer, we'll record your status as Yes.

²ERISA 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 STATUSAre you subject to TEFRA?³ ☐ Yes ☐ No

³If 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.	Cellphone () –		
Email	How should we correspond with this person? (select 1 only) <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.	Cellphone () –		
Email	How should we correspond with this person? (select 1 only) <input type="checkbox"/> Email <input type="checkbox"/> Mail			

Business name (please print): _____

8A SELECT BENEFIT OFFERINGS

Please indicate below if you'll offer a single plan or bundled plans. When bundling medical plans, please note that you can choose no more than 1 Added Choice® plan. Out-of-area plans do not count toward the limit of 3 medical plans. Refer to the Rating and Underwriting Assumptions Policy to see if your group qualifies. When bundling family dental plans, please note you can only choose 1 Traditional and 1 Dental Choice (PPO) plan OR 1 Voluntary Traditional and 1 Voluntary Choice (PPO) plan. Indicate which specific plan or plans you wish to offer along with any dental plan(s). If you're offering different plans to different classes of employees, please provide details of plan offerings in the comments section.

Buy-up options — Any of the medical plans can be paired with an adult vision or adult vision and massage buy-up option listed below, with the exception of the Standard plans. When selecting a plan with one of these buy-up benefit options, please check the appropriate box next to your medical plan selection.

Vision — \$200/2 years adult vision hardware benefit and vision exam

Massage — \$25 copay for massage with a 12-visit limit per calendar year. Choice plans are subject to different cost shares for PPO and nonparticipating providers. Cost shares subject to deductible on HSA-qualified high deductible plans.

	Medical plan(s)	Buy-up option		HSA/HRA/FSA selection(s)
		Vision	Vision and massage	
1st plan		<input type="checkbox"/>	<input type="checkbox"/>	
2nd plan		<input type="checkbox"/>	<input type="checkbox"/>	
3rd plan		<input type="checkbox"/>	<input type="checkbox"/>	
Out-of-area		<input type="checkbox"/>	<input type="checkbox"/>	

High deductible health plans (HDHPs) are health savings account (HSA) qualified. If you selected an HDHP medical plan above, please indicate if you'd also like Kaiser Permanente to administer your HSA health payment account. **If you select Yes, a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.**

HSA administered though Kaiser Permanente? ☐ Yes ☐ No

☐ Check this box if you are a religious employer (as defined in ORS 743A.066(4)) and do not want to include coverage for contraceptives or abortion procedures in the medical benefit plan(s) you've selected above, because these services are contrary to your group's religious tenets. The group will be required to complete an attestation.

	Family dental plan(s)
1st plan	
2nd plan	

8B MEDICAL PLANS

Medical plan options

Traditional Plans	The following consumer-directed health plans are available with traditional plans: FSA. KP OR Platinum 0 KP OR Gold 0		
Deductible Plans	The following consumer-directed health plans are available with deductible plans: HRA, FSA, stacked HRA/FSA. <div> <div>KP OR Platinum 250</div> <div>KP OR Platinum 500</div> <div>KP OR Gold 1000</div> <div>KP OR Gold 1500</div> <div>KP Oregon Standard Gold</div> </div> <div> <div>KP OR Gold 2000</div> <div>KP OR Silver 3000</div> <div>KP OR Silver 4000</div> <div>KP OR Silver 5000</div> <div>KP Oregon Standard Silver</div> </div> <div> <div>KP OR Silver 6000</div> <div>KP OR Bronze 7000</div> <div>KP OR Bronze 9200</div> <div>KP Oregon Standard Bronze</div> </div>		
HSA-Qualified High Deductible Health Plans	The following consumer-directed health plans are available with the high deductible health plans: HRA, HSA, FSA, stacked HRA/FSA. KP OR Silver HSA 3500 KP OR Bronze HSA 7100		
Kaiser Permanente Plus™ Plans	The following consumer-directed health plans are available with KP Plus plans: FSA. KP OR Platinum KP Plus 0		

Business name (please print): _____

Kaiser Permanente Plus™ Deductible Plans	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
Added Choice® Plans	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 ¹	KP OR Gold Added Choice OOA 1000 ¹	KP OR Silver Added Choice OOA 4000 ¹
	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 ¹	KP OR Silver Added Choice OOA 3000 ¹	KP OR Bronze Added Choice OOA 7000 ¹

¹Added 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 PEDIATRIC DENTAL PLAN OPTIONS (Oregon Health Insurance Marketplace—certified)

We're required to include Oregon Health Insurance Marketplace—certified pediatric dental benefits with your medical plan(s). By enrolling in a Kaiser Permanente Small Business Medical Plan, each employee and each of his/her dependents will also be enrolled in a separate Oregon Health Insurance Marketplace—certified pediatric dental plan unless you've purchased other pediatric dental coverage certified by Oregon Health Insurance Marketplace. Employees won't be charged for pediatric dental coverage unless they have eligible children on the plan. If no attestation is provided and no plan is selected, we will enroll your group in the lowest-cost pediatric dental plan.

Please select your requested pediatric dental plan from the choices below.

Traditional Plan Options:*

- ☐ KP OR Pediatric Traditional 80 Dental Plan
- ☐ KP OR Pediatric Traditional 100 Dental Plan
- ☐ KP OR Pediatric Traditional 100 + Ortho Dental Plan

Choice Plan Options:

- ☐ KP OR Pediatric Choice 80 Dental Plan
- ☐ KP OR Pediatric Choice 100 Dental Plan
- ☐ KP OR Pediatric Choice 100 + Ortho Dental Plan

If you've already acquired pediatric dental coverage from another carrier, we'll rely on your confirmation. Please select from one of the following:

- ☐ Enroll my group in the pediatric dental plan along with the Small Business Medical Plan that I have chosen; or
- ☐ I have purchased pediatric dental coverage with another carrier.

*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.

8D FAMILY DENTAL PLANS

Family dental plan options (these stand-alone dental plans are available Outside Market only)

Traditional²	KP OR Family Traditional — \$1000 KP OR Family Traditional — \$1000/\$50 Ded KP OR Family Traditional — \$1000/\$100 Ded KP OR Family Traditional — \$1000/\$50 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/\$50 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
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Business name (please print): _____

Voluntary Traditional²	KP OR Family Traditional — \$1000/\$50 Ded — Voluntary	KP OR Family Traditional — \$1500/\$50 Ded — Voluntary	KP OR Family Traditional — \$2000/\$50 Ded — Voluntary
Dental Choice (PPO)	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
Voluntary Choice (PPO)	KP OR Family Choice — \$1000/\$50 Ded — Voluntary	KP OR Family Choice — \$1500/\$50 Ded — Voluntary	KP OR Family Choice — \$2000/\$50 Ded — Voluntary

²Traditional 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.

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 X	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)
- Exhibit B to OAR 836-053-0015 (find this Exhibit at dfr.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
- 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 dfr.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 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 I have purchased pediatric dental coverage certified by Oregon Health Insurance Marketplace either through KFHPNW or 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. 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 X	Date