

2026 New and Renewing Large Group Application

All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Company's legal name	DBA(s)
Group number	

State in which the contract is based (select one) Oregon Washington (Clark and Cowlitz counties)

Coverage requested

New coverage _____ Submit this application, copy of selected proposal(s), and enrollment forms.
For timely processing, please return this form by the first of the month prior to
your effective date.

Coverage renewal _____ Complete sections I, III, V, VI, and VII. If you are making benefit changes or
changes affecting your rate, attach a copy of the selected proposal(s).

Term of contract _____ through _____
Date Date

Is your group new to Kaiser Foundation Health Plan of the Northwest (KFHPNW)?

So that your application can be processed quickly, please use this coverage checklist to make sure the
application materials are complete.

Completed and signed application (includes tax identification number and workers'
compensation information).

Completed and signed employee enrollment forms and waiver information.

Check made out to KFHPNW for the first month's premium (no postdated checks).

Section I: Plan and optional rider selection

Plans and riders offered and underwritten by **KFHPNW**

MEDICAL PLANS

Base plan (Please check the plan(s) you would like and write in the selected plan(s) name.)

Traditional plan _____

Deductible plan _____

High deductible health plan (HDHP, HSA-qualified) _____

Kaiser Permanente Plus™ plan _____

Kaiser Permanente Plus™ deductible plan _____

Dual Choice PPO™ plan _____

Dual Choice PPO™ HSA-qualified plan (HDHP) _____

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Plans and riders offered and underwritten by **KFHPNW** *continued*

Added Choice® plan (point of service)¹ _____

Added Choice® HSA-qualified plan (point-of-service HDHP)¹ _____

Do you have employees who both live and work outside our service area?² Yes No

PPO Plus plan² _____

PPO Plus HSA-qualified plan (HDHP)² _____

Early retiree/employer-sponsored Senior Advantage _____

Riders (Please check each rider you wish to purchase and indicate the rider description [e.g., prescription plan \$10/\$20/\$40/\$250].)

Outpatient prescription drug _____

Supplemental tier for preventive drugs (non-ACA) _____

Alternative care (Oregon) _____

Massage therapy (Washington) _____

Fertility treatment _____

Hearing aid (Oregon) _____

Pediatric vision hardware and optical services _____

Pediatric vision hardware and optical services enhanced benefit (Oregon)³ _____

Adult vision hardware and optical services _____

Dental accidental injury (Oregon) _____

Travel immunizations (excludes PPO Plus) _____

Medical plan accumulation (out-of-pocket expenses, applicable deductibles, and benefit limits)
Calendar year Plan year (not common)

Note any reimbursements you provide your employees toward their deductible, copays, and coinsurance. Be specific as to reimbursement annual maximum and what cost shares it applies toward:

IMPORTANT: You must attach a copy of all selected proposals and return them with this form.

DENTAL PLANS

Base plan (Please check the plan you would like and write in the selected plan name.)

Traditional Dental plan _____

EPO Dental plan _____

PPO Dental plan _____

Riders Dental office copay (traditional plans only) _____ Deductible (individual/family) _____

Dental orthodontics rider _____

Dental implant rider _____

¹Added Choice plans are only available for renewing groups and groups with 500+ eligible employees.

²For Washington-situs groups, if you have employees who both live and work outside Clark and Cowlitz counties, they must be enrolled in an out-of-area PPO Plus.

³Not available with Dual Choice PPO, Added Choice (POS), or out-of-area PPO Plus plans.

Section II: Premium and eligibility¹

Plan premium rates

(Please write the plan name and premium rates for each premium tier and each plan below.)

Plan name					
Employee					
Employee/Spouse/ Domestic Partner ²					
Employee/Family					
Employee/Child(ren)					

Do your eligibility rules allow for mid-month effective dates? Yes No

If effective date is other than first of the month for new eligibility or end of the month for terminations, please select payment rule based on eligibility:

Enrolled or termed 1st–31st and full premiums.

Enrolled 1st–31st full premiums. Termed 1st–15th pay \$0 premiums, termed 16th–31st full premiums.

Enrolled 1st–15th full premium, 16th–31st \$0 premiums. Termed 1st–31st full premiums.

Enrolled 1st–15th full premium, 16th–31st \$0 premiums. Termed 1st–15th \$0 premiums, termed 16th–31st full premiums.

Premium prorated.

Other (requires approval): _____

¹For the state of Washington, if you use a Custom Employee Enrollment Application, Kaiser Foundation Health Plan of the Northwest must receive an electronic copy. Custom Employee Enrollment Applications must meet all state requirements and be filed with the state by Kaiser Foundation Health Plan of the Northwest.

²A person who is legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Oregon or Washington, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your group.

<p>Representation regarding waiting periods</p> <p>Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.</p> <p>In addition, Group represents that eligibility data provided by the Group to Company will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.</p> <p>Termination processing</p> <p> Last day of the month following or coinciding with eligibility end date</p> <p> Date eligibility ends</p>		<p>Overage dependent limiting age (cannot be under 26)</p> <p>To _____ years</p> <p>Overage student limiting age (cannot be under 26)</p> <p>To _____ years</p>	
<p>This plan will cover</p> <p> Employees and dependents</p> <p> Employees only</p> <p> Surviving dependents</p> <p> Special eligibility _____</p> <p> (requires approval)</p>	<p>As required by state law, coverage for state-registered domestic partners is included in all large group plans.</p> <p>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.</p>		
<p>Number of eligible employees</p> <p>_____</p>	<p>Number of ineligible employees and full-time equivalents</p> <p>_____</p>	<p>Total number of employees</p> <p>_____</p>	

Section III: Employer information			No change	
Type of business	NAIC code (required)	Tax identification number		
Please check all that apply: Publicly traded corporation Partnership Privately held corporation Limited partnership State government Proprietor Local government Not-for-profit Church group Control group Corporation Other				
In business since				
Do you have workers who are independent contractors or who do seasonal work? Yes No				
Group plan sponsor Association Employer Labor organization Trustees or fund established by one or more employers or labor organizations				
Is the business a branch office? Yes No		Is the business a subsidiary? Yes No		
Contract signor/primary contact				
Name				
Address	City	State	ZIP	
Email	Telephone	Fax		
Billing contact				
Billing name	City	State	ZIP	
Billing address				
Email	Telephone	Fax		
Corporate headquarters address (if different from above)	City	State	ZIP	
Has your firm ever contracted with KFHPNW? Yes No If so, what was the legal name of the contracting firm? _____ Dates of previous contract with KFHPNW _____				
Are your benefit plans subject to the ERISA claim regulations issued by the U.S. Department of Labor? Yes No				

Third-party administrator for COBRA enrollment/billing (if applicable)			
Name			
Address	City	State	ZIP
Email	Telephone	Fax	
Section IV: Insurance information (prior to this contract)			No change
Workers' compensation/state industrial carrier	Policy number(s)		
Current health insurance carrier	Policy number(s)		
Address	City	State	ZIP
Current dental insurance carrier	Policy number(s)		
Open enrollment period _____ through _____		Effective date	
Renewal notification 90 days 120 days Other (how many days?) _____ (requires approval)			
Do any of your employees have Medicare? Yes No		If retirees are 65 or older, how is your retirement drug plan set up?	
Retiree eligibility age No retirement plan offered Younger than 65 65 or older	Medicare Part D Retiree Drug Subsidy (RDS) Other		

Section V: Multiple carrier requirements and contractual provisions

Multiple carrier offering

Is KFHPNW the only medical and/or dental carrier offered by the group? Yes No

If no, complete the following information:

Name of other carrier _____

Number of employees enrolled with other carrier _____

Name of other carrier _____

Number of employees enrolled with other carrier _____

Section VI: Employer contribution (upon effective date of this contract)

The group will contribute the following amounts of the monthly premium. If different employee classes are chosen, please indicate the contribution for each class. The minimum employer contribution amount is 50% of the employee premium for the lowest-cost medical plan or (nonvoluntary) dental plan.

	Description	% or \$ of employee premium	% or \$ of dependent premium
Medical plan 1:			
Medical plan 2:			
Dental plan:			
Class of employee:			
Class of employee:			
Class of employee:			

For renewing groups, is this a change in the employer contribution percentages? Yes No

Section VII: Producer of record (agent)

No change

Please complete this section if you are represented by one of our appointed health insurance producers.

Effective date _____, employer hereby appoints _____

producer of _____ (agency) as producer of record to represent the employer in matters of group health benefits provided by KFHPNW and/or its subsidiaries. This appointment rescinds all previous appointments and will remain in effect until terminated in writing by either party.

Producer may make requests concerning premiums, benefits, eligibility requirements, and other matters relating to health coverage. The employer understands that commissions due to the producer for services provided pursuant to the appointment are governed by an agreement between the producer and KFHPNW.

Producer phone number: _____ Producer email: _____

Producer/commission

Premiums include the following producer/commission level: _____% of premium.

Section VIII: Authorizing signature(s)

This form is not valid if selected proposals are not attached and if it is not signed.

My company acknowledges that eligibility for domestic partners will comply with state law.

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).

Authorized employer signature	Title	Date
Print name of principal/corporate officer	Title	Date
If you are a producer who completed this application on behalf of a client, please indicate so by signing.	Title/firm name	Date

For Washington state employers: You acknowledge by your signature that the information you have supplied on this form is true and correct. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If you use a custom enrollment application, it must meet requirements for Washington custom enrollment applications and we must receive an electronic copy of your enrollment application.

For Oregon state employers: You acknowledge by your signature that the information you have supplied on this form is true and correct. 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. If you use a custom enrollment application, we must receive an electronic copy of your enrollment application.

