

# Master application for groups of 51 or more employees

Select ONE OR MORE coverage options:

**Kaiser Foundation Health Plan of Washington (KFHPWA)**

Core Provider Network HMO  
 Connect Provider Network Virtual Plus<sup>1</sup>

**Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO)**

Access PPO Provider Network Access PPO  
 Options Provider Network KP Plus Options<sup>2</sup>

Summit PPO Provider Network Summit PPO<sup>1</sup>

**Delta Dental of Washington (DDWA)**

Health360

## 1. GENERAL GROUP INFORMATION

**Effective date:** \_\_\_\_\_

Group number(s): \_\_\_\_\_

**Group's legal name:** \_\_\_\_\_

Doing business as (if applicable): \_\_\_\_\_

Group's physical/mailling address: \_\_\_\_\_

Name of CEO, president, or owner: \_\_\_\_\_

Title: \_\_\_\_\_

Type of business: \_\_\_\_\_ SIC #: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ How long in business? \_\_\_\_\_

Parent company: \_\_\_\_\_

Affiliates/subsidiaries/other office locations to be covered: \_\_\_\_\_

**Primary group contact:** \_\_\_\_\_ Title: \_\_\_\_\_

Business address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Billing contact name:** \_\_\_\_\_ Title: \_\_\_\_\_

Billing address (if different than business address): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**COBRA billing contact the same as billing contact?** Yes No If no, please complete the following:

COBRA billing contact name: \_\_\_\_\_ Title: \_\_\_\_\_

Billing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

To sign up for the Kaiser Permanente employers website, please see the instructions on [kp.org/wa/business](http://kp.org/wa/business).

<sup>1</sup> For employers that have employees located in King, Snohomish, Pierce, Kitsap, Thurston, or Spokane counties.

<sup>2</sup> Available for Options renewing plans only.



Delta Dental of Washington



## 2. EMPLOYEE ELIGIBILITY

Open enrollment month(s): \_\_\_\_\_

This group defines a bona fide employee as one who works a minimum of \_\_\_\_\_ hours

per week  per month

Employees will be eligible for benefits upon **(select one)**:

Date of hire

First of the month following:  Date of hire  30 days  60 days

First of the month following or coincident with:  Date of hire  30 days  60 days

Other – No longer than 90 days from date that employee is otherwise eligible to enroll.

Any orientation period required for an employee to be eligible to enroll may not exceed one calendar month (please specify).\*

\_\_\_\_\_  
\_\_\_\_\_

Employee transfers from part-time to full-time **(select one)**:

Probationary period begins upon date employee transfers to full-time.

Probationary period is retroactive to original date of hire.

Rehire policy:  None **OR**

Waive probationary period if hired within:  30 days  60 days  90 days

Other \_\_\_\_\_

Coverage terminates:  Date of termination  End of month following termination

Other \_\_\_\_\_

**Note:** Continuation of coverage is available upon request in accordance with Washington state law to employers who choose to exercise this option for their employees who become ineligible for group coverage.

Other classes of eligible employees or dependents: \_\_\_\_\_

**Note:** Children are eligible until age 26, in accordance with federal and state laws.

Other classes or eligibility information:\* \_\_\_\_\_

**Note:** State-registered domestic partners will be treated as spouses as required by Washington state law.

Other domestic partner coverage?  Yes  No

The employer agrees to make the following contribution toward medical and dental when applicable toward the employee and dependent coverage:

Employee \$ or % \_\_\_\_\_ Dependents \$ or % \_\_\_\_\_

**HRA or HSA Annual Contribution \$ or %** \_\_\_\_\_

\*Attach additional sheets if necessary.

**Note:** Underwriting guidelines require at least 50% contribution on both medical and optional dental

coverage for employees.

### 3. GROUP PARTICIPATION

**3A. Total number of employees on payroll, regardless of hours worked** \_\_\_\_\_

**3B. Employees not eligible to enroll**

i. Employees working fewer than the minimum hours (see **Section 2**) \_\_\_\_\_

ii. Employees who are fulfilling their new hire probationary period + \_\_\_\_\_

iii. Employees who are temporary, seasonal, or substitute + \_\_\_\_\_

iv. Employees paid via IRS Form 1099 + \_\_\_\_\_

v. Employees whose class is ineligible for group coverage;  
description of group's ineligible class: \_\_\_\_\_

\_\_\_\_\_ +  
(For example, government plan, other group coverage, collective bargaining agreement)

**Total employees not eligible to enroll (the sum of i. through v.)** = \_\_\_\_\_

**3C. Number of eligible employees not enrolling due to coverage under a government plan (Medicare/Medicaid, TRICARE) or other group coverage with a valid waiver** \_\_\_\_\_

**3D. Total number of employees eligible to enroll (3A minus 3B minus 3C)** = \_\_\_\_\_

**3E. Total number of eligible employees enrolling** \_\_\_\_\_

**3F. Percent of eligible employees enrolling (3E divided by 3D)** = \_\_\_\_\_ %

**3G. Does your plan cover retirees?**  
 Yes  No If yes, number of retirees eligible for benefits \_\_\_\_\_

**3H. Number of COBRA/continuation of coverage subscribers, if applicable** \_\_\_\_\_

**3I. Does the number of employees reported in 3A include all employees eligible on a worldwide basis?**  
 Yes  No If no, what is the total number of worldwide employees? \_\_\_\_\_

**3J. Does the number of employees reported in 3A include eligible employees employed outside Washington state?**

Yes  No If yes, please provide number of employees in each state

State: \_\_\_\_\_

# of employees: \_\_\_\_\_

**Note:** Underwriting guidelines require that 75% of all eligible employees are enrolled in company-sponsored health coverage and dental if applicable, excluding those waiving coverage.

## 4. FEDERAL REQUIREMENTS

**Tip:** If you need assistance, we recommend that you inquire with a benefits consultant or legal counsel. The summaries below are not intended to be or replace legal advice. It is the group's responsibility to inform us if facts change that would cause the group's answers below to change.

**4A. TEFRA/DEFRA:** Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age?

Yes. This plan will pay primary to Medicare as required by federal law.

No. This group has fewer than 20 employees.

**Tip:** These requirements generally do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current or preceding calendar year. For these small group plans, Medicare pays primary to the group plan.

"Employees" include all full-time and part-time employees as well as those employees on disability and subject to FICA taxes. See 42 CFR 411.106 for further information about which individuals constitute an employee for this purpose.

**4B. COBRA:** Is the group subject to COBRA?  Yes  No

**Tip:** Generally, this applies to a non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year.

"Employees" are full-time and part-time common-law employees. Self-employed workers are defined in 26 CFR 54.4980B-2.

**4C. OBRA:** Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

Yes. This plan will pay primary to Medicare as required by federal law.

No. This group has fewer than 100 employees.

**Tip:** Generally, these requirements apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the tip in 4A above for a definition of "employee" for this purpose.

**4D. ERISA:**

Group Requirements	Responses	Additional Requirements	Notes
Is the group subject to Employee Retirement Income Security Act (ERISA)?	(please mark one) Yes    No <input type="checkbox"/> <input type="checkbox"/>	(if applicable)	Per Section 104 of ERISA, your group may be required to file IRS Schedule C (Form 5500)

If yes, enter the month the ERISA plan year ends: \_\_\_\_\_ Form 5500 Plan Number: \_\_\_\_\_

If no, give the legal reason for exemption:  Government or public plan  Church plan

Other (please specify): \_\_\_\_\_

**Tip:** Generally, ERISA applies to all employer health plans except government, public, or church plans. Nonprofit status alone does not exempt an employer from ERISA.

**Note:** Form 5500 Plan Number:

If applicable, enter the 3-digit plan number reported on IRS Form 5500 filed with the DOL. If there is more than one value, separate the numbers with a semicolon in the field above.

## 5. STATE REQUIREMENTS

The Washington State Office of the Insurance Commissioner (OIC) requires us to file all customized enrollment forms whether paper or electronic to ensure they include various consumer protection disclosures.

- I attest that the group uses the Kaiser Permanente Standard Enrollment Form.
- I attest that the group does not use the Kaiser Permanente Standard Enrollment Form. All custom enrollment forms/screenshots must be sent with the renewal/new sale paperwork so they can be filed with the contract and approved by the OIC. Failure to do so will delay the processing of enrollment and issuance of the group contract and Evidence of Coverage.**

**Note:** If using our standard census template spreadsheet or sending enrollment using an EDI/834 file, you must indicate how you are collecting this information by selecting one of the options above.

## 6. OTHER CARRIER INFORMATION

Do you offer another medical plan to your employees, other than one of our plans?  Yes  No

If yes, please list the carrier name: \_\_\_\_\_

## 7. CONFIRMED MEDICAL RATES AND BENEFITS SELECTION

**7A.** Please sign attached medical rate confirmation sheet. Confirmed RQ/QR number: \_\_\_\_\_

**7B.** Rate Stabilization Reserve Funding Agreement  Yes  No

If yes, Terminal Liability is held by:  Client  KFHPWA or KFHPWAO

**7C.** If offering an HRA or HSA, do you want an integrated banking arrangement with HealthEquity?

Yes  No

**7D.** Grandfathered plan: In order to be in compliance, our documentation must establish the following grandfathered plan criteria have been in place since March 23, 2010. Does the group meet the criteria below?  Yes  N/A

- The plan was not amended to eliminate benefits for a specific condition.
- The percentage of fixed amount cost-sharing percentage requirements for the plan, if applicable, was not increased when measured from March 23, 2010.
- The fixed cost-sharing requirements other than copayments did not increase by a total percentage more than the medical inflation rate plus 15%.
- Copayments did not increase by more than the medical inflation rate plus 15% or \$5 (adjusted for inflation), whichever is greater.
- The employer's contribution rate for any tier of coverage did not decrease by more than 5%.
- The plan was not amended to impose an annual dollar limit or to adopt an overall annual dollar limit on benefits that is less than the lifetime limit.

## 8. DELTA DENTAL OF WASHINGTON BUNDLING

By bundling Delta Dental of Washington with Kaiser Permanente medical, you will receive a consolidated invoice. Dental coverage is provided by Delta Dental of Washington, 400 Fairview Avenue N., Suite 800, Seattle, WA 98109-5371.

**8A.** Confirmed Health360 dental bundling:  Yes  No

**8B.** Please sign attached dental rate confirmation sheet. Confirmation number: \_\_\_\_\_

Eligibility for the optional dental plan will be shown in the benefit booklet as defined by the group.

A group must have enrolled at least 51 subscribers to qualify and, in addition, 75% of eligible employees must participate.

## 9. PRODUCER INFORMATION

Do you have a producer of record?  Yes  No If no, continue to **Section 10.**

I have appointed \_\_\_\_\_ as my producer of record with respect to the coverage described in this application, effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

Producer's name: \_\_\_\_\_ Title: \_\_\_\_\_

Producer's company name: \_\_\_\_\_

License number: \_\_\_\_\_

Producer/representative's Social Security or tax ID number: \_\_\_\_\_

Company address: \_\_\_\_\_

Consultant  Producer  Commission to be paid to: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## 10. ACKNOWLEDGMENTS AND CERTIFICATION

Applicant acknowledges that if the requested coverage is accepted by the applicable health carrier (KFHPWA or KFHPWAO) and optional dental carrier (DDWA) under the carrier's current rules and practices, a coverage agreement will be issued and effective on the date determined by the carrier(s). Applicant further acknowledges and agrees that payment of any premium due for the coverage shall constitute applicant's acceptance of the coverage agreement issued.

For Section 2, "Employee Eligibility," applicant attests to having clearly stated the terms of eligibility conditions or waiting periods imposed on employees before they are eligible to become covered under the terms of the plan. Applicant further attests it will provide us with any changes related to such conditions.

If Section 9 has been completed, applicant has appointed the named producer as the Producer of Record with respect to the coverage requested in this application. No producer has the authority to guarantee that the health carrier will accept this application for coverage and no producer has the authority to contract on behalf of the health carrier.

KFHPWA, KFHPWAO, and DDWA reserve the right to review applicant's State of Washington Employer's Quarterly Report, Form 5208A, to confirm eligibility and participation requirements. Under Washington law, it is 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.

**Signature by applicant's authorized representative shall constitute applicant's 1) request for coverage; 2) acknowledgment and acceptance of all terms, conditions, and information contained within this application form; and 3) certification that all information provided by applicant on this form is accurate and complete.**

Group representative name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of representative: \_\_\_\_\_ Date: \_\_\_\_\_

## 11. PRODUCER CERTIFICATION (complete ONLY if producer is named in Section 9)

**Producer certification:** I certify that, to the best of my knowledge, the information on this application is accurate.

Producer's name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of producer: \_\_\_\_\_ Date: \_\_\_\_\_

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057.

All dental plans offered and underwritten by Delta Dental of Washington, 400 Fairview Avenue N., Suite 800, Seattle, WA 98109-5371.