KAISER PERMANENTE®

Colorado Small Group

EMPLOYER APPLICATION

CONNECT for HEALTH COLORADO

Please complete all information.
We can't process incomplete applications.

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 ( ) –	Fax ( ) –				

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)*	SIC code (4 digits)*	Website

*Find your NAICS and SIC codes at **https://www.naics.com/search**

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 date: / /

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 and must apply as 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 ( ) –		

3B EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Total ______________ Authorized company signer's initials ______________

Note: If the total number of employees noted above is 100 or fewer, skip the following and go to section 3C.

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE),* refer to your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year.

Total ______________ Authorized company signer's initials ______________

Business name (please print): ______________________________

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible W-2 employees.** Total _______________ Authorized company signer's initials _______________

Please provide the total number of **eligible 1099 contracted employees**. Total _______________ Authorized company signer's initials _______________

Please provide the total number of **enrolling employees.** Total _______________ Authorized company signer's initials _______________

Hours per week employees must work to be eligible for coverage:[1] _______________
Employee only coverage?[2] ☐ Yes ☐ No

[1]Minimum 24+ hours per week
[2]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.

4 DOMESTIC PARTNER COVERAGE

Do you wish to select Domestic Partner Coverage? ☐ Yes ☐ No

If *Yes*: ☐ Same Sex Domestic Partner Only
☐ Opposite Sex Domestic Partner Only
☐ Same and Opposite Sex Domestic Partner

Employees who are enrolling a domestic partner must submit a domestic partner affidavit along with their Colorado Uniform Application.

5 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

6 ERISA STATUS

Is your company subject to ERISA?[3] ☐ Yes ☐ No If you do not select an answer, we will record your status as *Yes*.

[3]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're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

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

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Business name (please print): ______________________________

8 CONTRACT SIGNER INFORMATION

There's only 1 contract signer. This principal person is responsible for signing the group agreement, providing renewal information, and 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

Street address (mailing)	City	State	ZIP

Office phone	Ext.	Fax	Cellphone
( ) –		( ) –	( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

9 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, but isn't authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed.

☐ **Check here if same as contract signer.**

First name	MI	Last name

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cellphone
( ) –		( ) –	( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

10 BILL DELIVERY PREFERENCE

Let us know how you prefer to receive your bills.

☐ I would like paperless bills
☐ I would like paper bills

I understand that if I do not sign up for paperless billing, Kaiser Permanente will mail a paper statement. I further understand that I can opt in or out of paperless billing at any time. 30-day notification is required to make changes in billing notification processing. Authorized company signer's initials ______

11 EMPLOYEE RATE INFORMATION

Kaiser Permanente offers member-level rating for groups applying through the Colorado Health Exchange.

Member-level rating is based and calculated on a variety of factors, such as:

- Benefit plan(s) selected
- Member demographics
- Geographic location

Because rates are calculated at the individual member level, the individual members of a particular group's plan may experience rate changes that differ from the group's overall change.

Business name (please print): ____________________

12 MEDICAL PLANS

PLAN INFORMATION[1]

Groups with at least 3 enrolled employees can select up to 3 plans if each of those employees is on a different plan.

HMO	☐ KP CO Platinum 0/15 RX Copay†	☐ KP CO Gold 0/30 RX Copay†	
Deductible HMO	☐ KP CO Platinum 400/20 ☐ KP CO Gold 500/30 ☐ KP CO Gold 1500/30 RX Copay†	☐ KP CO Silver 2500/45 ☐ KP CO Silver 4000/50 RX Copay† ☐ KP CO Virtual Complete™ Silver 6800/50 RX Copay† ☐ KP CO Bronze 7000/60 RX Copay†	☐ KP CO Virtual Complete™ Bronze 8700/40
Consumer Directed	☐ KP CO Gold 1750/30/HSA ☐ KP CO Silver 3000/30/HSA	☐ KP CO Silver 4000/30/HSA ☐ KP CO Bronze 6250/50/HSA	☐ KP CO Bronze 7000/100% HSA

KP SELECT[1,2]

The following plans are only available to employees living in qualified zip codes in Colorado Springs

HMO	☐ KP Select CO Platinum 0/15 RX Copay†	☐ KP Select CO Gold 0/30 RX Copay†	
Deductible HMO	☐ KP Select CO Platinum 400/20 ☐ KP Select CO Gold 500/30 ☐ KP Select CO Gold 1500/30 RX Copay†	☐ KP Select CO Silver 2500/45 ☐ KP Select CO Silver 4000/50 RX Copay† ☐ KP Select CO Virtual Complete™ Silver 6800/50 RX Copay† ☐ KP Select CO Bronze 7000/60 RX Copay†	☐ KP Select CO Virtual Complete™ Bronze 8700/40
Consumer Directed	☐ KP Select CO Gold 1750/30/HSA ☐ KP Select CO Silver 3000/30/HSA	☐ KP Select CO Silver 4000/30/HSA ☐ KP Select CO Bronze 6250/50/HSA	☐ KP Select CO Bronze 7000/100% HSA

†These plans cover all prescription drugs at copay, however many other plans also cover brand and generic drugs at copay.

Employer Groups and Insurance Carriers are required to provide the Summary of Benefits and Coverage (SBC) to plan participants and beneficiaries together with the Colorado Supplement to the Summary of Benefits and Coverage (COSSBC). Please visit **https://account.kp.org/broker-employer/resources/employer/plans/smallbusiness/summary-benefits-coverage/** to download or print your Summary of Benefits and Coverage (SBC).

[1]The Colorado Division of Insurance requires carriers to notify you of the following: This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act.
[2]Employees who live in Colorado Springs may only purchase a KP Select Plan

Business name (please print): ____________________

13 MEDICARE

Effective January 1, 2006, Medicare Part D prescription drug coverage is available to Medicare eligible retirees/employees. Kaiser Permanente's Small Group Medicare health plans include Medicare Part D prescription drug coverage.

☐ Our group doesn't currently have any Medicare eligible retiree/employees.

Some Kaiser Permanente medical plans may not meet the Medicare Part D creditable coverage requirements. Please consult your broker or Kaiser Permanente sales representative for guidance.

14 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan of Colorado (KFHPCO) 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.

15 FOOTNOTE INFORMATION

*Full Time Equivalent employees is calculated by counting the number of people who worked an average of 30 or more hours per week. Then add to this amount the number of hours worked per week by non-full time employees divided by 30. You may exclude seasonal employees that work 120 days or fewer per year.

16 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

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 Kaiser Foundation Health Plan, or KPIC. I've 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.

Agent name | License number

Phone ( ) – | Fax ( ) – | Cellphone ( ) –

Email

Firm name | EIN/TIN | Kaiser Permanente broker firm ID

Street address | City | State | ZIP

Agent/broker signature X | Date

General agency

Business name (please print): ______________________

17 AGREEMENT AND SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHPCO and KPIC, 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 KFHPCO and KPIC 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.

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 W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that the minimum participation requirement of eligible employees are covered by group coverage. I agree to abide by the Kaiser Permanente deductible funding policy, which doesn't permit directly funding or reimbursing employees for any deductibles, coinsurance, or copays, except for our designated HRA plans, in accordance with the federal tax laws for HDHP/HSA plans or PPO medical plans.

I attest that my company isn't 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 **https://account.kp.org/broker-employer/resources/employer/plans/smallbusiness/summarybenefits-coverage/**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I understand that the KP CO PPO medical plan doesn't include the pediatric dental essential health benefit coverage required by the Affordable Care Act. For any employee who's enrolled in this plan, I have or will purchase such coverage separately.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente Plans X	Date

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 1-100 ELIGIBLE EMPLOYEES UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE CLAIMS EXPERIENCE OF OR ANY HEALTH STATUS RELATED FACTOR OF THE SMALL EMPLOYER AND ITS EMPLOYEES AND THEIR DEPENDENTS IN THE GROUP.