



KAISER PERMANENTE

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson Street
Rockville, MD 20852
703-873-1500

DISTRICT OF COLUMBIA SMALL EMPLOYER (2-50) GROUP APPLICATION

SECTION I. APPLICATION

**This application must be completed in its entirety.
Please sign, date and return this application to the Kaiser Permanente sales office.**

_____, ("Applicant") is applying to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser Permanente") for a Group Agreement to become effective _____ or the effective date approved by Kaiser Permanente, whichever is later. No retroactive effective dates for new groups are permitted. Along with this application for coverage under a Group Plan is a one-month deposit in the amount of \$_____. This deposit will be applied to the first premium due for this coverage. **If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership service representative before signing this application or card.**

I certify that I have read and understand all of the information contained in this Group Application.

Soliciting Agent Signature

Date

Dated at (location)

Applicant Signature

Date

Dated at (location)

"Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant"

TO BE COMPLETED FOR BROKERED SALES ONLY	
Broker Name	General Agent Name (if applicable)
Broker Mailing Address	Broker Tax ID
City, State Zip	Kaiser Permanente Appointment Date
Broker Telephone Number	Broker License Number/Jurisdiction
Broker Email Address	Broker Fax Number
Additional Notes:	

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
DISTRICT OF COLUMBIA SMALL EMPLOYER (2-50) GROUP APPLICATION

Section II. APPLICANT STATEMENTS

THE APPLICANT CERTIFIES that the company has a legitimate business operation, and does not exist for the sole purpose of obtaining health coverage.

THE APPLICANT AGREES that 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 Kaiser Permanente for any purpose of this Applicant or any Group Agreement issued pursuant to this Applicant.

THE APPLICANT AGREES that he/she is answering to the best of his/her knowledge and belief. **Kaiser Permanente is permitted by law to cancel for** fraud or intentional misrepresentation of material fact by the small employer. **THE APPLICANT FURTHER AGREES** that, if this is the case, Kaiser Permanente's obligations shall consist only of the return of any subscription charges actually received by Kaiser Permanente, less the amount of any benefits paid under the coverage.

THE APPLICANT AGREES that the effective date will be determined by Kaiser Permanente and will be the latest of:

- the date this application is given written approval by Kaiser Permanente; or
- any requested effective date not prior to the date the Applicant signs this Agreement and Kaiser Permanente approves the Application; or
- the date Kaiser Permanente establishes for coverage to begin, in the event that this application is not accompanied by all information needed by Kaiser Permanente.

Full first months' payment must be received and Kaiser Permanente must approve the application in writing before the plan becomes effective.

THE APPLICANT CERTIFIES that, unless Kaiser Permanente agrees otherwise in writing, all persons to be covered, except retirees, 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 works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. "Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

THE APPLICANT AGREES to furnish Kaiser Permanente 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 Kaiser Permanente's agents have the authority to:

- modify this application form
- waive the answer to any question on this application form;
- bind Kaiser Permanente 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;
- bind Kaiser Permanente by making any promise or representation not contained in this Application form.

THE APPLICANT DECLARES that the applicant's representative has read the above statement and that the answers to all of the questions are complete and true, to the best of his/her knowledge.

THE APPLICANT AGREES

- 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 Kaiser Permanente; and,
- that no waiver or charge will bind Kaiser Permanente unless signed by an Executive Office of Kaiser Permanente;
- that Group coverage will only be provided for persons eligible under the plans issued.

THE APPLICANT AGREES to provide Kaiser Permanente, in writing, of group and employee eligibility. Kaiser Permanente reserves the right to inspect the records of the Group in order to verify the eligibility of employees and their dependents. In addition, the Group must annually complete and return, in advance of the contract anniversary date, any and all documents requested by Kaiser Permanente in order to certify the Group as a small employer.

**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
DISTRICT OF COLUMBIA SMALL EMPLOYER (2-50) GROUP APPLICATION**

SECTION III. GROUP INFORMATION

Legal Name of Organization		Legal Status <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other		
Main Address		Nature of Business		
City State Zip		Standard Industrial Classification (SIC) Code		
Local Address (if different from Main Address)		Billing Address (if different from Main Address)		
City State Zip		City State Zip		
Federal Tax ID Number	Length in Business	Workers Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No (Provide Carrier Name & Policy Number, if available)		
Name of CEO or President	Title	Telephone	Fax	E-mail address
Name of Administrator or Contact	Title	Telephone	Fax	E-mail address
Are there any affiliates or subsidiaries to be covered? If "Yes", please provided details below				<input type="checkbox"/> Yes <input type="checkbox"/> No

Company Name		_ Affiliate _ Subsidiary	Company Name		_ Affiliate _ Subsidiary
Address			Address		
City State Zip			City State Zip		
Will this plan coverage replace any existing or previously in force Group Plan?		_ Yes _ No	If Yes, Carrier Name and type of Coverage (e.g. HMO, POS, PPO, etc.)		Termination Date
Regular full time employees are eligible for group coverage. Such employees may apply for the coverage after being employed for the applicable waiting period(s). The waiting period for the new employee is (check one):			<input type="checkbox"/> Date of hire <input type="checkbox"/> 1 st of the month following date of hire <input type="checkbox"/> 1 st of the month following 30 days after date of hire <input type="checkbox"/> 1 st of the month following 60 days after date of hire <input type="checkbox"/> 90 th days after date of hire <input type="checkbox"/> Other (please indicate) _____		
Will the waiting period be waived for current employees who have not satisfied their current waiting period? Check one:					_ Yes _ No
Have you, any affiliate or subsidiary had prior coverage with Kaiser Permanente? If Yes, complete next line					_ Yes _ No
Prior Group Number	Prior Group Name (if different)	Prior Coverage Period		Reason For Termination	
		From	To		
ELIGIBILITY/PARTICIPATION * IF MORE THAN 20, Kaiser Permanente will assume COBRA is applicable					
Employer's Contribution To Plan Costs (percent)		Indicate the TOTAL number of employees for each category below			
Employee	Dependent	Employees	Full Time 30+ week	Part-Time	Other

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DISTRICT OF COLUMBIA SMALL EMPLOYER (2-50) GROUP APPLICATION**

SECTION IV. GROUP CENSUS

Please complete the information below for all employees. Kaiser Permanente will use this information to determine the following:

1. that you, the Employer, satisfy the definition of "small employer" as defined by the **District of Columbia** ; and
 2. that your employees satisfy the definition of "eligible employee" as defined by the **District of Columbia** .
- Kaiser Permanente reserves the right to request additional information to assist in determining the group size and the number of eligible employees.

*** Please use ALL of the following codes which apply to identify "Insurance Coverage"**

- 01 Kaiser Permanente member or applying for coverage
- 02 Spousal Coverage
- 03 Medicare A & B applying for coverage
- 04 COBRA/Continuation Beneficiary

**** Please use ALL of the following codes which apply to identify "Other" employee status**

- 08 Seasonal/Temporary (not part-time)
- 09 New employee in probationary period
- 10 Retiree
- 11 Self-Employed Individual

Signature of Account Executive, Broker, or Consultant			Name and Title (please print or type)		
Date	Signed and Dated at (location)			City State Zip	
Telephone Number	Fax Number	E-mail Address			

SECTION VII ACCEPTANCE/APPROVAL

Following approval of this application, Kaiser Permanente shall issue a Group Agreement and/or any applicable amendments:

**KAISER PERMANENTE APPROVAL
APPROVAL BY KAISER PERMANENTE PRICING AND UNDERWRITING DEPARTMENT**

Signature of Authorized Pricing and Underwriting Representative			Name and Title (please print or type)		
Date	Signed and Dated at (location)			City State Zip	
Telephone Number	Fax Number	E-mail Address	Effective Date of Group Coverage		

DO NOT WRITE BELOW THIS LINE – FOR KAISER PERMANENTE USE ONLY

Group Number Assigned ____	<input type="checkbox"/> Signature	<input type="checkbox"/> Select	OAD	Average Age	Initial Contract Period Begin Date	Initial Contract Period End Date
Funding Type:	<input type="checkbox"/> Non Direct	<input type="checkbox"/> Direct	Proration/Effective Status		No. Eligible	No. Enrolled
<input type="checkbox"/> Full	<input type="checkbox"/> Partial		<input type="checkbox"/> F/MB	<input type="checkbox"/> H/DE		
<input type="checkbox"/> Dental Plan: _____	<input type="checkbox"/> NO Dental	Step Type = 3	Rate Level = _____			
Rates: HMO Plan: _____	Individual		Rates: POS Plan: _____	Individual		
	Two Party			Two Party		
	Family			Family		
	Copayment Maximum			Deductible		
	Individual			Co-insurance		
	Family			OOP Maximum		

Additional Notes:

PLEASE PRINT

Marketing Sales Representative Sign-off:	Date:
Pricing and Underwriting Sign-off:	Date:
Group Database Sign-off:	Date:
Membership Accounting Sign-off:	Date: