

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
MARYLAND SMALL EMPLOYER 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. Section 15-1212(b) of the Insurance Article permits cancellation 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 (1) an individual who (a) is an employee, sole proprietor, self-employed individual, partner of a partnership, or independent contractor who is included as an employee under a health benefit plan; and (b) works on a full-time basis and has a normal workweek of at least 30 hours; or (2) a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code who: (a) has a normal work week of at least 20 hours; and (b) is *not* covered under a public or private plan for health insurance or other health benefit arrangement. An "eligible employee" does not include an individual who works (a) on a temporary or substitute basis; or (b) except for an individual described in item (2) above, for less than 30 hours in a normal workweek.

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 Officer of Kaiser Permanente;
- that Group coverage will only be provided for persons eligible under the plans issued.

THE APPLICANT certifies that it has

- been offered the Comprehensive Standard Health Benefit Plan as defined by Maryland law; and
- informed of the point-of-service option as defined by Maryland law; and
- informed of the dental point of service option as defined under Maryland law.

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.

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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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SECTION V. ELECTION OF COVERAGE BY APPLICANT

OFFERING SCENARIO

Kaiser Permanente must be offered exclusively.
Exception: Kaiser Permanente does not have to be the exclusive carrier for dental services.

MINIMUM PARTICIPATION REQUIRMENTS

Check All that Applies:

If there are no employees participating in the Medical Savings Account, a minimum of 75% of the eligible employees must enroll under Kaiser Permanente. If one or more employees participate in the Medical Savings Account, the group is not subject to a minimum participation requirement.

Check One:

- We are a Maryland Small Group and have no employees participating in the Medical Savings Account, thus subject to a minimum participation of 75% of the eligible employees. In applying the minimum participation requirement to determine whether the 75% of participation is met, Kaiser Permanente may not consider as eligible employees those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Standard Plan.
- We are a Maryland Small Group and have one or more employees participating in the Medical Savings Account, thus not subject to a minimum participating requirement.

DELIVERY CARE SYSTEM

Applicant has the choice of selecting the delivery care system for which eligible employees shall be enrolled. Applicant may elect to cover part-time employees, employees covered under another public or private health benefit plan or other health benefit arrangement. There may be an additional premium for these options. **Part-time employee** means an employee who has a normal workweek of at least 17_ but less than 30 hours per week and has been continuously employed for at least 4 consecutive months. **Other coverage** means another public or private health benefit plan or other health benefit arrangement

Check All that Applies:

- [Signature]
- [Select]
- Coverage will be offered for part-time employees
- Coverage will be offered to employees with other health care coverage
- Coverage will be offered to both part-time employees and employees with other coverage
- Coverage **will not** be offered to part-time employees
- Coverage **will not** be offered to employees with other health care coverage

GROUP ELIGIBILITY REQUIRMENTS

Applicant must attach to this Application, any group eligibility criteria.

- Check here to indicate that eligibility criterion is attached.

PRODUCT OFFERING

Check One

- HMO: Applicant elects to provide HMO coverage only to eligible employees** . Applicant understands that each eligible employee may elect a mandatory point-of-service option as indicated in the **POINT-OF-SERVICE OPTIONS DISCLOSURE STATEMENT** of this Application. Each eligible employee must indicate selection of the mandatory point-of-service option. Failure to do so will result in HMO coverage only. Applicant certifies that it has read and understands the **Point-of-Service Options Disclosure Statement** and has provided notice of the availability of the additional benefit to its eligible employees. Applicant shall provide Kaiser Permanente with the names of those employees electing the mandatory point-of-service option.
- Point-of-Service:** Applicant elects to provide Point-of-Service (POS) to **all** eligible employees.
- HMO and POS:** Applicant elects to provide both HMO and Point-of-Service (POS) coverage to all eligible employees. The eligible employee elects either HMO coverage or POS coverage.
- Mandatory Dental Point-of-Service:** Applicant understands that each eligible employee may elect a dental point-of-service option as indicated in the Point-Of-Service Options Disclosure Statement of this Application. Each eligible employee must indicate selection of the dental point-of-service option. Failure to do so will result in no dental point-of-service coverage. Applicant certifies that it has read and understands the Point-of-Service Options Disclosure Statement and has provided notice of the availability of the additional benefit to its eligible employees. Applicant shall provide Kaiser Permanente with the names of those employees electing the dental point-of-service option. **This mandatory dental point-of-service does not apply if the Applicant elects not to purchase a Dental Rider and if Kaiser Permanente is not the sole offering for dental care services.**

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POINT-OF-SERVICE OPTIONS DISCLOSURE STATEMENT

The following provisions apply only if Kaiser Permanente is the sole offering for health care or dental services.

- Under Maryland law, your employees may purchase a point-of-service option, a dental point-of-service option or both as an additional benefit. A point-of-service option allows your employees to obtain covered health care services from physicians and other providers outside the HMO network. A dental point-of-service option allows your employees to obtain services from dentists and other providers outside the provider panel. You have the choice to pay these point-of-service options, pay a percentage of the cost of these options, or require your employees to pay for the entire cost of these options. The cost of the point-of-service options is identified in your proposal.

Applicant certifies that it has read and understands this disclosure statement and has provided notice of the availability of these additional benefits to its eligible employees.

POINT-OF-SERVICE OPTION SELECTION

- Applicant DECLINES mandatory POS offering.** By declining, Applicant understands that employees shall not be entitled to POS as an additional benefit.
- Applicant ACCEPTS mandatory POS offering** . Please indicate below the employees who have chosen the point-of-service option:

- Check here if additional space is needed and attach an additional sheet or sheets to this application providing requested information.
- Check here if requested information is being provided in another format (e.g., spreadsheet, payroll listing, etc.) and attach.

DENTAL POINT-OF-SERVICE OPTION SELECTION: This mandatory dental point-of-service does not apply if the Applicant elects not to purchase a Dental Rider or if Kaiser Permanente is not the sole carrier for dental services

- Applicant DECLINES mandatory dental point-of-service option**
- Applicant ACCEPTS mandatory dental point-of-service option.** Please indicate below the employees who have chosen the point-of-service option:

- Check here if additional space is needed and attach an additional sheet or sheets to this application providing requested information.
- Check here if requested information is being provided in another format (e.g., spreadsheet, payroll listing, etc.) and attach.

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SECTION VI. NON-BINDING ACCEPTANCE

SUBJECT TO FINAL APPROVAL BY KAISER PERMANENTE'S PRICING AND UNDERWRITING DEPARTMENT

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 checked="" type="checkbox"/> Dental Plan: _____	<input checked="" type="checkbox"/> NO Dental	Step Type = 3	Rate Level = 3	Region (Check One): <input type="checkbox"/> Baltimore <input type="checkbox"/> Washington		
Rates: HMO Plan: _____	Individual		Rates: POS Plan: _____	Individual		
	Two Party			Two Party		
	Family			Family		
	Copayment Maximum			Deductible		
	Individual			Co-insurance		
Family		OOP Maximum				
<u>Additional Notes:</u>						
PLEASE PRINT						

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