



KAISER PERMANENTE

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

COMMONWEALTH OF VIRGINIA 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)

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.
COMMONWEALTH OF VIRGINIA 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 UNDERSTANDS that provisions related to renewability of policies and contracts and that provisions affecting pre-existing conditions (if any) shall be stated in the Group Agreement or Evidence of Coverage issued to the group.

APPLICANT UNDERSTANDS the premium rate is established based on the cost of providing health care, the demographic make-up of the group and the health of the individuals within the group.

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 Essential and Standard health benefit plans as defined by Commonwealth of Virginia, and
- been informed of the option to choose coverage that does not provide dental benefits under an Essential or Standard health benefit plan; and
- been informed of the point-of-service option as defined by Commonwealth of Virginia 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.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
COMMONWEALTH OF VIRGINIA 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		

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

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 REQUIREMENTS

Check All that Applies:

We satisfy the Minimum Participation Requirement as follows:

- If our plan is non-contributory, then we must enroll 100% of the net eligible employees.
- If our plan is contributory, then we must enroll 75% of the net eligible employees.

GROUP ELIGIBILITY REQUIREMENTS

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

- Check here to indicate that eligibility criterion is attached.**

DELIVERY CARE SYSTEM

Applicant has the choice of selecting the delivery care system for which eligible employees shall be enrolled.

- [Signature]
- [Select]

EMPLOYER WAIVER OF ESSENTIAL AND STANDARD COVERAGE

Applicant may waive the Essential and Standard health benefit plans and elect another product offering that is offered to all small groups. Applicants choosing to be covered under an Essential or Standard health benefit plan have the option to choose coverage that does not provide dental benefits.

(Check only when electing to waive)

- I hereby elect to waive coverage under the Commonwealth of Virginia Small Group Essential and Standard benefit plans and to elect another benefit plan offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter "Kaiser Permanente"). I understand Kaiser Permanente must offer coverage under the Commonwealth of Virginia Small Group Essential and Standard benefit plans upon each contract anniversary date.

**EMPLOYER SELECTION OF ESSENTIAL OR STANDARD COVERAGE
(Check only when electing coverage)**

I hereby elect

- Essential health benefit plan coverage
- Standard health benefit plan coverage

If you selected either Essential or Standard coverage above, please review the following and select one of the boxes below:

Small employers electing to be covered under an essential or standard health benefit plan have the option to choose coverage that does not provide dental benefits. The Small employer making such election must purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 (§38.2-4500 et seq.) of Title 38.2 of the Code of Virginia.

- I elect to provide dental benefits provided as stated under Standard and/or Essential
- I elect NOT to provide dental benefits through Kaiser Permanente but will provide dental benefits through another dental carrier

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.

