Group Number_____

KAISER PERMANENTE

❑ **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS)**
2101 East Jefferson Street
Rockville, MD 20852

❑ **Kaiser Permanente Insurance Company (KPIC)**
One Kaiser Plaza
Oakland, CA 94612

VIRGINIA SMALL GROUP EMPLOYER APPLICATION

Section 1: APPLICANT'S INFORMATION

Legal Business Name			Legal Status (check box) ❑ Partnership ❑ Corporation ❑ LLC ❑ Sole proprietor ❑ Other_____	
D/B/A - Doing Business As (if applicable)				
Street Address				
City	State	ZIP code		
Executive Contact	Title		Phone	Fax
Email Address	Type of Business		Business License Number	
Federal Tax ID Number / SIC/NAICS Code	**Requested Effective Date**		Company Inception Date	

All employees must be covered by Worker's Compensation, unless not required to be covered by law. I attest that the following information is correct:

Worker's Compensation Carrier's name_____

I am exempt from providing Worker's Compensation coverage for the following reason(s): _____

_____

Are there any affiliates or subsidiaries to be covered? ❑ Yes ❑ No If yes, please provide details below			
Company Name	❑ Affiliate ❑ Subsidiary	Company Name	❑ Affiliate ❑ Subsidiary
Address		Address	
City, State, ZIP		City, State, ZIP	
Federal Tax ID Number	Phone Number	Federal Tax ID Number	Phone Number

Section 2: BILLING INFORMATION

Same as applicant information? ❑ Yes ❑ No ❑Third Party Administrator (TPA) If yes, skip to section 3

The TPA is a person or company that is contracted for the purpose of administering the group's membership or billing.

Billing Address	City	State	ZIP Code
Billing Contact	Title	Phone	Fax
For office use only			

Proration/Eff status	F/MB	H/DE	D/DE	SEC
Jurisdiction: VA				

DO NOT ALTER THIS DOCUMENT EXCEPT TO FILL IN THE BLANKS AND CHECK THE BOXES PROVIDED. Due to regulatory requirements, this application will not be accepted if any other changes are made. Complete this application in its entirety, in black ink, and sign and return it to your Sales Representative. If you have any questions concerning the benefits and services that are provided by or excluded under the benefit plan selected, please contact your account manager or sales representative before signing this application.

Group Number_____

Section 3: RATES AND BENEFIT PLAN REQUESTED

Choose your Small Group health plan(s) which include pediatric dental essential health benefits, adult preventive dental benefits, along with pediatric and adult cosmetic dental services. [HMO], [Deductible HMO], [HDHP], [Added Choice POS], and [Flexible Choice] (Option 1: HMO) benefits are underwritten by KFHP-MAS. [Flexible Choice](Option 2: POS & Option 3: Out-of-network) benefits are underwritten by KPIC. **Groups may select up to four medical plans.**

NOTE: [Flexible Choice] are Signature Service Delivery Option only.

MEDICAL			**DENTAL ENHANCEMENTS(OPTIONAL)**	
Product	**Service Delivery Options**		**Product**	
[HMO]:	❑ Signature	❑ Select	❑ [DHMO1 Adult dental rider – age 19 & older]	
[Deductible HMO]:	❑ Signature	❑ Select	❑ [POS 1 Adult dental rider – age 19 & older]	
[HDHP]:	❑ Signature	❑ Select	❑ [POS 2nd Level Adult dental rider – age 19 & older]	
[Added Choice POS]:	❑ Signature	❑ Select	❑ [POS 3 Adult dental rider – age 19 & older]	
[Flexible Choice]:	❑ Signature	Initial Premium:		Employer Contribution %
Plan Name:		Plan Name:		
Plan Name:		Plan Name:		

Dental benefits are underwritten by KFHP-MAS and administered by Dominion National. Groups may select one dental plan. Groups that select the composite premium rating calculation may not select a dental enhancement.

Section 4: EMPLOYEE ELIGIBILITY

Please enter the applicable number of employees by work location, if applicable, below. Please duplicate the chart as needed to account for each work location. Refer to healthcare.gov or your legal counsel for information on calculating the number of full-time, part-time, full-time equivalent, and eligible employees.

By signing this application, you attest to the following:

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law.

I attest that all eligible employees not taking coverage have completed and signed a valid waiver.

Work Location (by State)	**Number of Employees**				
	Full Time Employees (Includes Owner)	**Part Time Employees**	**Full-time Equivalent Employees**	**Eligible Employees**	**COBRA**
Total:					

I attest that my company will offer group health coverage to all (check one):
❑ Part-time employees and full-time employees ❑ Only full-time employees

Will coverage be provided to domestic partners? ❑ Yes ❑ No

How many employees are waiving coverage? | Is your Business operating as Seasonal only? ❑ Yes ❑ No

Section 5: BROKER INFORMATION (to be completed for brokered sales only)

Broker Name Jonathan Katz		Broker Firm Name Katz Insurance Group	
Street Address 1404 Northpoint Glen Court		City Herndon	
State VA	ZIP 20170	Phone 703 707 8270	Fax 703 783-5913
Email Address jkatz@vamedicalplans.com	Life & Health License Number 137422	Federal Tax ID Number 47-2708150	
General Agent Name EBCA			

Your broker is/may be paid commissions and other financial incentives by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Group Number_____

Section 6: EMPLOYER AGREEMENT

The employer agrees to the following eligibility requirements:

1) The applicant is a group of 50 or fewer full time equivalent employees.
2) To meet the following **minimum participation requirement:**
   - ❑ If the plan is non-contributory, then 100% of the eligible employees must be enrolled.
   - ❑ If the plan is contributory, then 70% of the net eligible employees must be enrolled.
     [Net eligible employees= Total eligible employees less employees with other health coverage.]
   - ❑ We are applying for coverage during the period that begins on November 15 and extends through December 15, thus not subject to a minimum participation or employer contribution requirement.
3) The applicant agrees that, unless KFHP-MAS/KPIC agrees otherwise in writing, all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are "Eligible Employees" of the applicant, or 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. At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees." "Employee" as the meaning given such term under section 3(6) or the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1002(6)). Independent contractors/1099 employees are not eligible for coverage.
4) Business certification
   We certify that our company has a legitimate business operation, and does not exist for the sole purpose of obtaining health care coverage.
5) 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 KFHP-MAS/KPIC for any purpose of this application or any group agreement that is issued pursuant to this application, except enrollment.
6) The applicant agrees to offer enrollment in the KFHP-MAS/KPIC products to all individuals entitled to coverage on conditions no less favorable than those for any other health care plan available through the group.
7) The applicant agrees that a bona fide employer/employee relationship exists with respect to each subscriber to be enrolled in the KFHP-MAS/KPIC products. This requirement does not apply to eligible Taft-Hartley trusts and partnerships.
8) The applicant agrees that it assumes responsibility for, and all liability related to, its determinations regarding the eligibility status of each eligible employee and his/her dependents, and understands that KFHP-MAS/KPIC will rely on such eligibility determinations in effectuating coverage. Furthermore, the applicant agrees it will be financially liable to KFHP-MAS/KPIC for any errors and/or omissions.
9) The applicant agrees to maintain employee enrollment/waiver records for the purpose of regulatory state audits.
10) The applicant agrees that as required by state law, employer group has a worker's compensation coverage for its employees.
    - ❑ The group carries workers' compensation insurance.
    - ❑ The group does not carry workers' compensation insurance.
11) The applicant agrees to hold an open enrollment period 30 days prior to the group's contract renewal date, during which all individuals entitled to coverage are offered a choice of enrollment in the KFHP-MAS/KPIC products.
12) The applicant agrees that the group coverage applied for in this application will not become effective until:
    a) This application is approved by KFHP-MAS/KPIC
    b) An advance payment equal to an estimated one-month premium is received by KFHP-MAS/KPIC and
    c) That if the cost of the coverage is to be contributory, the required percentage of the eligible employees shall have agreed to make the required contribution.
13) The applicant agrees that the agent or the broker do not have the power on behalf of KFHP-MAS/KPIC, to make or modify any application for coverage, to make any promise or representation, or to waive any of the companies' (KFHP-MAS/KPIC) rights or requirements.

Group number_____

14) The employer retains sole discretion whether to open and contribute, and how much to contribute, to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) account for employees who enroll in the KP VA Gold 1400/0%/HSA/Dental, KP VA Silver 1500/30/HSA/Dental, KP VA Silver 2500/30/HSA/Dental, KP VA Silver 4000/0%/HSA/Dental, KP VA Bronze 6550/0%/HSA/Dental, KP VA Bronze 5750/30/20%/HSA/Dental.

15) The Applicant attests that the company does meet the definition of "small employer" as defined by applicable federal and state law. By signing this application, the applicant acknowledges that this attestation may be subject to verification and agrees to provide KFHP-MAS with any information necessary to do so.

16) The eligibility data provided by my company to KFHP-MAS will include coverage effective dates for my company's employees in compliance with my company's eligibility rules and the waiting period requirements in the Patient Protection and Affordable Care Act and regulations, which require that waiting periods may not exceed 90 days. All full time and part-time employees, if the employer elects to offer part-time employees coverage, are considered eligible employees on the effective date.

Section 7: GROUP ACKNOWLEDGEMENT

I understand and agree, as the employer, that the statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that such statements and answers; a) will become part of any group agreement which may ultimately be issued by KFHP-MAS/KPIC; and b) are made to induce KFHP-MAS/KPIC to issue the group coverage as applied for. I have the authority to make the statements and representations contained in this application and to execute this application on behalf of the group.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

Signed at_____ on _____
City State Month Day Year

By (full name in print)_____

Signature_____ Title _____

For KFHP-MAS office use only

☐ Approved	Authorized by: _____
☐ Declined	Date Finalized: _____
☐ Closed Out	Approved Effective Date: _____/_____/_____
☐ Withdrawn	

Comments: